HOUSE OF COMMONS

Health Committee

Oral evidence: Complaints and raising concerns, HC 350

Tuesday 8 July 2014

Ordered by the House of Commons to be published on 8 July 2014.

- Care Quality Commission
- General Medical Council
- Nursing and Midwifery Council
- Department of Health
- NHS England

Watch the meeting

Members present: Dr Sarah Wollaston (Chair), Rosie Cooper, Andrew George, Robert Jenrick, Barbara Keeley, Charlotte Leslie, Grahame M. Morris, David Tredinnick Valerie Vaz

Questions 395-528

Witnesses: **Dean Royles**, Chief Executive, NHS Employers, **Rob Webster**, Chief Executive, NHS Confederation, and **Chris Hopson**, Chief Executive, Foundation Trust Network, gave evidence.

Q395 Chair: Good afternoon and thank you very much for coming. Congratulations to Mr Royles on your new appointment and I am sorry that we shall be losing you. Can I start by asking you to introduce yourselves, and maybe I can start with you, Mr Royles?

Dean Royles: I am Dean Royles. I am chief executive of the NHS Employers organisation and am shortly moving to Leeds Teaching Hospitals as director of HR and organisational development.

Chair: Thank you.

Rob Webster: I am Rob Webster. I am the chief executive of the NHS Confederation.

Chris Hopson: I am Chris Hopson. I am the chief executive of the Foundation Trust Network.

Q396 Chair: Thank you very much. Perhaps I could kick off today by asking you to comment on whether or not you feel a trust should be judged to be performing better if it has too few complaints or too many complaints.

Rob Webster: I am happy to start, if you like, Chris, and then bring you in. The conversation I have with members and the conversation I had as a trust chief executive was that we wanted to try and promote a culture where people could raise concerns, make comments about the care that they received and complain, and actively encourage complaints if things went wrong, because complaints are a really good set of insights into how you address issues, whether they are clinical or non-clinical. You need to have a fine judgment about whether too many complaints is a good thing or not. In that environment, where you want incidents to be raised because it is a good way of improving learning and in an environment where you want to get comments, concerns and complaints out in the open, in the short term I think we need to see an increase in the number of complaints which are registered in the NHS.

Q397 Chair: If a trust is not having enough complaints recorded, that should be a marker for a poorly performing trust.

Rob Webster: I think the question that you would then start to ask is why that is the case. It may be that they have a fantastic culture where they are getting upstream with the complaints and starting to address them before they become formal. That happens in many organisations already and that would be the best recourse. All our experience is that, if you can get the clinicians, the patients and their families together early to talk about what the issues are, they get resolved much quicker, and the learning gets addressed and then adopted in the organisation.

Q398 Chair: Is there an organisation that perhaps the panel could tell us of where this happens exceptionally well?

Rob Webster: Chris, do you want to talk about anything from your trust experience?

Chris Hopson: There are a number of trusts where you have really seen a significant improvement over the last 18 months to two years. There is a lot that has changed, both in the external environment in which trusts operate, but also in trust performance itself. We see trusts these days making a much more significant investment in the quality of their complaints handling; we see boards receiving reports that are more detailed; we see governors in foundation trusts taking more of an interest in this area. We see a number of changes and therefore improvements being made.

Hillingdon Hospitals—a trust I visited a week or 10 days ago—has really placed a huge emphasis on this and taken some really big steps forward. Some of the big teaching hospitals that we know—Cambridge university, Oxford university and Newcastle are three very good examples—are absolutely getting this right.

Q399 Rosie Cooper: Primarily, I will start off with Chris, if I may. In your memorandum you talk about the importance of a provider board generating a culture of

learning from complaints, which everybody would agree with, and say that that should be transparent and not create an atmosphere of fear or blame. I would like to ask you a couple of questions. Do you think the presence—as in Liverpool Community Health NHS Trust—of HR at each of those meetings helps members of staff to be open and honest? Who do you think is responsible for the culture of an organisation? Who should be responsible for changing that culture, and how is it done? If I can, I will come back with another bit.

Chris Hopson: It is clearly very difficult for me to talk about individual trusts where I do not have personal experience and where I do not have management accountability, but there is absolutely no doubt that, in setting the culture inside an organisation and being accountable for it, it is the board, as we put in the memorandum. Again, our observation would be that particularly post-Francis, post-Mid Staffordshire, boards are focusing much more clearly on these issues and doing concrete things to improve the culture and to ensure that staff feel able to raise concerns.

It is interesting that, if you go to the staff survey data, you very clearly get 96% of staff saying that if they saw an incident, either they or a colleague actually raised it; 85% of staff say their organisation encouraged them to report errors, near misses or incidents. Our sense is that, if you were to take a summary judgment of where the NHS is up to on this, there are a lot of very good things that are going on, but we would be the first to acknowledge that more needs to be done.

Rob Webster: Can I add something around the board setting the culture? I think it is a great question about who sets the culture. We cannot emphasise strongly enough that NHS organisations operate in a system, and that is a system of providers of NHS care, which may be third sector, private sector or NHS organisations. They operate in a commissioning system and they operate in a regulatory system. All of those organisations contribute to the culture. The board conversations will be driven by many of the external factors that they face. So there will be pressure for boards to talk about performance, finance and hard data as well as, I think rightly, pressure on boards to think about the culture of openness and learning. Boards have to set the culture in that context, and we must look at that context as well as at what boards are doing.

Q400 Rosie Cooper: I know you are not saying this, but it is not okay for a board, for example, in very dire financial circumstances, where they are going to hell in a handcart because they are going to be a foundation trust, to put that before the benefit and safeguarding of their patients and their members of staff—to put it before everything. You are not saying that at all.

Rob Webster: Certainly not. I am sure Chris will be able to comment on this, but having been through the FT process personally, there is as much focus on the quality of governance and the standards of patient care now as there is on the financial bottom line. The changes that people go through in thinking about their service sustainability have to be well evidenced in terms of—sorry; I will say that again in English. In thinking about how services are delivered, one of the things we know is that over the next two to five years we are going to have to see some significant changes. All those changes have to be quality assured by the medical director and director of nursing, and in the best trusts they do that with the staff and all the evidence goes into the assessment. The idea that you can get through the FT pipeline just by focusing on the money is no longer appropriate.

Q401 Rosie Cooper: Can I ask you to consider your answer in relation to a community trust? I can tell you that in your seat sat David Bennett, who told us that there is no real measure of trying to evaluate how a community trust would meet those objectives you have just set out for an ordinary NHS trust.

Rob Webster: I know Chris wants to say something here, but, if you will allow me just a moment, I used to run a community trust and I was accountable for two things: the safety of every patient and the value of every penny. I took both of those things incredibly seriously. The data that I had around incidents, complaints, concerns, activity and waiting was significant. I could look at that on an individual basis and see whether services were safe or not. What I could not do was benchmark that against some of my colleagues. Having a national dataset where you can say that all community trusts are the same or you can measure them in comparable terms is more difficult. But individual organisations do have indicators, measures and surveys that they look at, whether it is their own personal SAF or patient survey, which gives them some reassurance.

Chris Hopson: One of the key changes that we have seen over the last couple of years is the introduction of the new CQC inspection regime, and if you look at the well-led domain it absolutely focuses very specifically on this area and assesses trust and foundation trust performance about how they are doing on complaints; and, again, as you probably know, for the first time they are drawing up a set of clear national standards which they will use in that inspection regime to judge how well a trust and a foundation trust is performing. We also know, if you look at the way that Monitor and the TDA interact with foundation trusts and trusts, that, again, these areas are getting a significantly greater focus than they have had before. A classic example would be that each foundation trust now has to do a three-year governance review. As part of that governance review, they will be looking at how they handle quality governance.

Q402 Rosie Cooper: I know Barbara wants to ask a question, so I will come back to bits of this a little later. All I will say to you is that Liverpool Community Health NHS Trust was fast-tracked to be a foundation trust. I called in the CQC; they were inspected on 10 domains; they failed all 10, got two enforcement notices and are subject to another CQC report in a couple of weeks. The ACAS report came out about bullying the staff and said, basically, that it is the worst they had ever seen. Yet using your parameters—

Chris Hopson: What we would then expect to happen in those circumstances—

Rosie Cooper: They were being fast-tracked for an FT. They were virtually at the door of Monitor. Monitor was in, inspecting.

Chris Hopson: Again, it is really difficult for me to comment on individual cases. What clearly happens in those cases where the CQC believes that the trust is seriously failing on quality grounds is that it goes into special measures and then the TDA can use its power, for example, to move the chair and the chief executive on, which we know has happened in a number of cases.

Rosie Cooper: Absolutely, and the chief exec has gone. Forgive me, but the point I was trying to make is that had I not called the CQC in, this would all still be going on. That was the point I was trying to get to. The indicators did not find this themselves.

Q403 Barbara Keeley: Patients and relatives often want to provide feedback on services without making a formal complaint—stopping short of a complaint. Do you think the current system provides adequate opportunities, and if you do not think they are adequate, how do you think it should be changed so they can provide that feedback?

Chris Hopson: Opportunity for what, sorry?

Barbara Keeley: Providing feedback short of a complaint.

Chris Hopson: We have seen trusts and our members over the last two years make really significant advances here. If you look at, for example, the information that is provided to patients—if we talk about the acute setting—when they first come in, that has significantly improved. We obviously have the friends and family test that has now been implemented, so there is a much greater emphasis on the value of collecting feedback. Again, if you point to the places where all of those changes have been implemented, what you are finding, in answer to the first question, is that the number of complaints may be reducing because—

Q404 Barbara Keeley: Not complaints; I said feedback.

Chris Hopson: What I was saying was that, because it is being captured at an earlier stage, patient feedback is being taken account of and those concerns are being rectified before you have to get them to the complaints stage. There is a whole bunch of things, we would argue, that we see our members doing to improve their performance in this area.

Rob Webster: I think it is a great question. For me, we need to be able to demonstrate that we are capturing compliments, concerns, comments and complaints—and we do it in real time and we do it better. There is a big push through the friends and family test to have a view of that. It is helpful but partial. If you look at patient reported outcome measures, such as, "How was your care today? Was your food hot? Could you eat it? Were you helped? Were people caring?", those are incredibly important. I think there should be a significant push—and there is in many trusts—to record that data in real time so that you can get reinforcement of all the fantastic things that happen, but also you get to address the things that are happening now in ways which make a difference to patients and their families.

Q405 Barbara Keeley: I think we still fall short of ways to provide feedback. Listen to Kate Granger talking about her own recent experiences as a clinician; I am thinking of things like being called "bed 7", or being called by her condition—those sorts of things—people with difficult information to get across to a patient not looking at them, all of that. Kate Granger speaks about her own experience, combining her useful knowledge as a clinician with the impact it has on her when those things happen. I do not think we have enough channels for that type of thing, which is meant to be positive. In my experience,

families and patients often want to ensure that if they give feedback about those things or other serious things—sometimes very serious things—it is acted out. Given that trusts are very large and complex, how can a patient who perhaps had a bad experience but does not want to make a complaint be sure that you act out what they say?

Chris Hopson: We have absolutely recognised that what we call closing the feedback loop—making sure that people are told what happens as a result of issues that they have raised—is a really important part of the process. Generally, we would all recognise that trusts and foundations trusts were not where they should have been three to five years ago, and we are recognising that performance is improving. That is a classic area.

When I was in Hillingdon hospital 10 days ago, one of the things that the chief executive was particularly proud of was the fact that in the work they now do, they very deliberately go back to each individual person who has submitted a formal complaint—and I know you were talking about concerns as well as complaints—and explain exactly what has happened as a result of that complaint being made.

Q406 Barbara Keeley: Should all trusts be doing that? That is a good example, but should they not?

Chris Hopson: Yes.

Q407 Barbara Keeley: If it is good that one does it, then they should all be doing it.

Chris Hopson: Yes. The way I would describe it is that trusts are on an improvement journey. It is getting better. There are lots of different bits of evidence we could point you to to show that it is getting better, but, to be frank, as ever, there is variation in performance and we know all trusts need to meet the quality and the standards of the best, and we need to do it as quickly as possible.

Can I make one other point, which I think is really important? It is important to try and get an overall picture of where we think standards of care are. There is one thing that we want to particularly point to, which is that every year the CQC does an in-patient survey and they interview 60,000 people across the NHS to ask them what their overall experience was of care. They do it on a scale of 0 to 10. In last year's in-patient survey only 7% rated the performance as either a 0, which is the bottom, or 1, 2 or 3, and 82% rated it 7, 8, 9 or 10. What we need to do is recognise that by and large—and this is confirmed in the Commonwealth Fund survey that came out, for example, last year—in an in-patient setting, the overall experience is of that kind of level.

Barbara Keeley: I have to say, though, that if that was TripAdvisor—the way you use indicators like that—you would never go back to somewhere to which you gave a 0 or a 1. To be honest, we have a worry if 7% of patients or their families are giving 0 or 1. I do not think you can rest on your laurels. That is fine.

Chair: I want to come to Robert; you wanted to raise a point as well.

Q408 Robert Jenrick: I had a pertinent example of a poorly handled complaint in my own constituency two weeks ago, where an elderly lady in her 90s had fallen off a scooter on a street in Newark and had had to wait three hours for an ambulance to arrive from East Midlands Ambulance Service without having any water. That was a very difficult situation for the lady involved. I am not asking you to comment on that case, but it was a case where a complaint was made—by me acting on the family's behalf as their MP—but then they never received any personal contact from the trust, or East Midlands Ambulance Service in this case, and, because it became a media story, the local newspapers and the national press put out an apology from the ambulance service without them ever having had a personal apology from the ambulance service involved. I wondered whether this raised issues about how you can have a very professional and responsive complaints system but which, almost by virtue of that, loses its personal touch. Nobody in this case thought to pick up the phone to the victim or the family involved. How can you maintain the balance between the two?

Rob Webster: That is obviously a poor example, and we would all feel that that was not the right outcome for that old lady or for the family. There is a simple golden thread through complaints, which I think most people know and is good practice, which is that you always say sorry, explain what you think has happened, and describe why it is not going to happen to anybody else. We see in most organisations that that is widely understood and, whether it is a front-line member of staff or the chief executive who is responding, that is what they should do. The personal touch is incredibly important, and in many trusts it will be the chief executive who signs off all the formal complaints.

As part of the good practice, certain things should happen almost immediately. In my own trust I used to have a standard, which was that you get an acknowledgment within 72 hours and we will ask you personally, "What do you want to get out of this complaint? How long do you want it to take? What do you want to happen with it?" You will have personal contact, and then you will get a response from the chief executive, which will not be a standard format: it will be about you and those three things—the apology, explaining what has happened and why it will not happen to somebody else.

Through NHS Employers, the Foundation Trust Network and our own organisation, we want to continue to perpetuate that. When it comes down to it, we are in a people business—we have people looking after people. Where that goes wrong, there needs to be a conversation.

Q409 Chair: Not an apology by press release, in other words.

Rob Webster: Certainly not, though sometimes what does and can happen is that people may feel they have to go to the media to get a response, and that would always be wrong. It may be the case that the media then gets into a position where things are being said in public to which the trust can never respond. We all know about confidentiality. Sometimes you are in a position where NHS bodies cannot say what they need to because of confidentiality, but the media can say what they like. That can sometimes feel like you are distanced or being unprofessional.

Chris Hopson: Hopefully, you will have heard of the Clwyd-Hart report on NHS complaints. One of the things that they recommended—and I was on the panel that was assisting Tricia Hart and Ann Clwyd on that report—which we thought was a very good recommendation, was that in as many circumstances as possible, as soon as the trust

receives a complaint, particularly a serious one, it should initiate a direct conversation with the patients concerned to ascertain, exactly as Rob said, "What are you seeking to get out of this complaint?", and "How would you like the complaint best resolved?" That is a recommendation that we have encouraged our members to take up, and we know large numbers of them have done so.

Rob Webster: That is a recognition of the fact that, statutorily, you have to respond within six months, but people want their complaint dealt with now, and organisations want good, learning organisations. Many of our members want to address people's concerns straight away.

Q410 Grahame M. Morris: Rob has just outlined a kind of exemplary approach to complaints handling. I want to ask about what difference the status of the person who is handling the complaint makes within an organisation; I know the chief exec would, as standard practice, sign it off. I also want to ask some questions about the resources, from your perspective. Are provider organisations making enough resources available to be effective in terms of real-time monitoring—feedback—ensuring that it is dealt with promptly and appropriately?

Rob Webster: I will make a comment about the system, if that is okay, and then Chris might want to comment about the providers. Many people's complaints now involve more than one organisation. Our members have been operating in environments that have become much more complex following the implementation of the Health and Social Care Act, so you have more commissioners and more providers. You might have one person who has complex needs and has seven or eight organisations involved in their care, and their complaint might need to have a response from all those organisations, which can cause a bit of delay, and a bit of extra resource may be required within the organisation.

I think we are operating in quite a complicated environment, which means we need to have good resources and people who can always put the patient first, in terms of the learning and the outcome for them, can negotiate with others around how the responses are going to be managed, and can make sure that the organisation is done in such a way that it meets the agreed outcome with the patient about how quickly the complaint gets dealt with.

This is the kind of environment that people have been operating in, and it is one which has been unstable over the last few years as organisations have come into play, as jobs have been filled and as people have moved around. I think that is partly behind some of the problems that we have had with some of the complaints handling, and part of the reason why we should feel a bit more confident for the future. Those relationships are getting back to being more stable, I would say, though the complexity of the pathways still exists. All organisations will have an escalation policy. If something comes in and it looks like a serious incident, then it does not matter who receives it; you escalate it through the clinical governance processes to the director responsible or the chief executives to get an immediate response to make sure the patient is safe.

Chris, I do not know if you want to talk about—

Chris Hopson: If you don't mind, I will tell you a very quick story of a trust that I visited, a classic district general hospital, which about 18 months ago, on their management data, which now incorporated complaints and satisfaction with them for the first time, highlighted that they had a problem. They got feedback from their governors that it was not going as well as it should have done. The chief executive basically was one of those chief execs who absolutely wanted to sign everything off personally and felt he had to send too many draft complaints back.

So they did a real piece of work on this, working together collectively together as a board. The four things they did that I thought were really interesting was, first, to identify that they had under-resourced the complaints department and that the person leading it was not of an appropriate seniority, so they recruited somebody from the Parliamentary and Health Service Ombudsman—somebody who was used to dealing with complaints.

The second thing they said that was very interesting was that that person was of a suitable seniority and knew how to deal with complaints; they were able to have the kind of robust conversation that was needed with the clinical staff inside the hospital so that, if that person felt they were not getting the right answer, they were able to really push back. That individual was then able, instead of doing a set formula for replying to complaints letters, to do a bit of analysis about exactly what kind of individual they thought they had on the end of the complaint. They then flexed the complaint letter and the response according to what they thought that person's needs were.

The other issue was that the chief executive absolutely asked the director of nursing to push this higher up her list of priorities and to focus on it. As a result, the quality of the whole complaints-handling system has significantly improved. The chief executive is now only sending back two out of 10 draft responses. When I asked him, "What really made the difference?", he said it was the combination of three things: the board really focusing on it, recruiting the right person to run the complaints department—which is absolutely the point you were making about resources—but, also, thirdly, ensuring that the director of nursing, a senior executive director, was putting a higher priority on it. So I do think there is a question of resourcing and culture, but it is a combination of all those things, not just the resourcing bit.

Q411 Grahame M. Morris: It is the status in the hierarchy of the individual who is appointed by the provider to do the investigation.

Chris Hopson: Yes, and I thought in particular that real bit about having somebody who is sufficiently robust, experienced and senior to have the quality of dialogue with senior clinical staff where on occasions, somewhat understandably, senior clinical staff may get quite defensive about what has gone on. Having somebody who is senior enough to be able to push back and really say, "No, that is not a sufficient answer," seems to me to be—and he certainly was arguing—an important issue in getting the right quality of response to complaints.

Grahame M. Morris: On the point you made about resourcing in that DGH you visited, which recognised it was under-resourced financially, what is your view on that, as

chief executive, given that a third of NHS trusts are predicting deficits by the year end? Is that having an impact on the amount of resources that are being allocated to this particular issue?

Chris Hopson: I cannot give you specific evidence on the relationship between current funding pressures. We are in the middle of the biggest and longest financial squeeze the NHS has ever faced. However, I would argue that, looking at the job that our boards are currently doing, this is absolutely what they are discussing on a very regular basis: "How do we strike that balance between, on the one hand, meeting the financial challenge that we have and, on the other, guaranteeing quality?" We would be the first to acknowledge—and we have said this to you in numerous bits of evidence—that that job is getting more difficult.

Rob Webster: It is important to say that often the jobs that are involved here, around patient advisory liaison service, complaints handling, tracking and making sure you have the administrative support, are the sorts of jobs people describe as being "bean counters" or "administrators who do not have a role." Then if you think about clinical commissioning groups, which have had a significant reduction in their management resources, which are asked to operate in a much more difficult environment, they need to make sure that they are able to prioritise this kind of work because it is essential support to clinical front-line services.

Q412 David Tredinnick: I want to ask some questions about support for patients wishing to complain and, if I may, address the first question to you, Mr Webster. In your memorandum you raise concerns that the complexity of new commissioning arrangements can leave patients confused about to whom they should complain. Is it fair to say that the new arrangements themselves have caused confusion?

Rob Webster: Yes. I think the NHS is a system, not a single organisation. Many patients think, and much of the story in the media and in broader society is, that the NHS is an organisation, and it is not: it is a system. I do not think there is a widely held understanding of what the role of the commissioners is, or who commissions different bits of the services that patients receive. Without that understanding, it can be difficult for people to know to whom they are going to complain.

Q413 David Tredinnick: Do you not think it is astonishing that, after all the effort that has gone into these reforms, you should be able to agree with me on that?

Rob Webster: It is not astonishing. It is a fact that, if you have a child with multiple issues, then the organisations that commission services for that child, if they have physical and mental health needs, might include NHS England, the local clinical commissioning groups, the local authority and the schools. Therefore, if you have a complaint about one element of their treatment, it will be confusing for you on the end of that, but what you will want as a patient and a family is to make sure you have joined-up services.

Q414 David Tredinnick: Is that your solution? What is the solution to this problem that we have teased out?

Rob Webster: There is a developing maturity around the arrangements, which I think is helpful. We are seeing people who pay for services—the commissioners—working much more closely together. Then I think we are seeing more joined-up services by providers. Whether you are complaining to the provider or the commissioner, you should be able to know that, whichever provider it is, or whichever commissioner, they will co-ordinate your complaint on behalf of the whole of the system. That is what is supposed to happen. If you look at what the Care Quality Commission were saying—that people should know their rights and have information about where to complain, and there should be a culture of openness around complaining—that leads us to a point where we could get somewhere where people understand who to complain to and it gets dealt with.

Q415 David Tredinnick: Through you, Chair, I do not know whether Mr Hopson wants to come in on that; he was making animated gestures then.

Chris Hopson: I thought the Parliamentary and Health Service Ombudsman case which came out a couple of weeks ago absolutely illustrated the fact that, quite often, patient journeys are not simple, and that you will cross potentially GP, community and acute services, and it is not entirely clear, if there has been a failure in care, exactly where that responsibility should sit. If you wanted to complain, as the parents of the child did, it was not entirely clear.

There are two things I would completely echo. We are getting a growing system maturity; people are learning how to co-ordinate effectively. There is also a duty on any provider or commissioner who receives a complaint to ensure that they liaise with the rest of the system, but I would argue that part of the problem here is that we have a fragmented health and care system, in which responsibility for providing care is split across a number of different organisations. Therefore, it is not entirely surprising that it is not clear who to complain to.

Q416 Chair: Following on from the point about primary care services—because we have focused very much up to now on providers of secondary care—from April 2013 it was switched to being a call centre in Leeds, and in my area, which is the far south-west of England, it now gets handled by an organisation in north London. There are therefore very few local-facing mechanisms for handling those complaints. It has been taken away from the CCGs, and formerly it was the PCTs. It seems to me that there is not a developing system maturity there. It strikes me that this is removing it from any local input. What is your view about having GP complaints from the south-west of England handled by a body sitting in north London?

Rob Webster: One of the consequences of the Act is that NHS England commissions primary care services. So, as a patient, if you have a complaint, you complain to the GP; and if you are not happy, you can go to the commissioner, which is NHS England. I would say that NHS England has fewer resources to cover more practices and is less local than PCTs would have been. My sense is that, just as we want to have core commissioning of primary care services, community and secondary care services, which NHS England is now promoting, you would want to ask how that helps with things such as an

understanding of where issues have happened in primary care in general practice. What must happen above all else is that we deliver the golden thread on complaints: the apology, the explanation of what has happened, and addressing the root cause so that it does not happen again.

Q417 Chair: But it strikes me that, if you are handling that complaint far removed from where the service is being delivered, that is making the system worse. You talked about a system maturity. It strikes me that that is not an example of system maturity; it is not giving you what we saw in the Francis recommendations, which was a locally-facing immediate response.

Rob Webster: I am sure my NHS England colleagues might want to comment on this later, but NHS England uses its local area teams to engage with local GPs, so it might go to Leeds to be farmed out to the local area team.

Q418 Chair: No, it is going to north London, which is not a local area team.

Rob Webster: Again, that arrangement, our members have found, does cause delay and means that you are not as close to the organisation as you would have been previously.

Q419 Chair: And, of course, that cross-border issue that you mentioned, where it involves several stages of a patient's journey, makes it even harder if part of the complaints system is far removed. Would you agree that that needs to change? Are you aware of other examples where that is causing a problem?

Rob Webster: I would say that if we have an environment where the vast majority of staff feel that they can raise incidents—and the vast majority of the surveys show improvements in this area—it is to the great credit of people in the service that that is happening, because some things are difficult and more complex. The new arrangements are difficult and more complex in the way that they are provided and commissioned than they were before. I do not think there is a simple solution to that. I think it comes back to how we make sure that somebody takes responsibility for co-ordinating the complaint when it is received, and that there is a duty on everybody to respond in a way which will make sure that the apology, the explanation of what has happened and the action is taken as quickly as possible.

Chris Hopson: As a point of principle, what you are saying seems to me to be absolutely right and is one of the things, as I was saying earlier, that the Clwyd-Hart report says, which is that a complainant should have the ability to speak to somebody who can speak with appropriate authority on behalf of an organisation that is being complained about, and have a realistic, proper and sensible dialogue with the complainant. By definition, having that dialogue at a local level, close to both the individual complainant and the organisation that is providing the care, would seem to me to be quite important.

Q420 Rosie Cooper: For whatever reason, do you think there is any gaming? If you were a chief exec and there was a really difficult, complex case, complaint and/or family, or

however you want to describe it, do you think there is any gaming, such as drawing it out, playing the long game, locally not agreeing a resolution, not coming back to the family or patient with a satisfactory response, knowing that the chances of the ombudsman investigating this case are very remote and that you will therefore get away with it—I use the words "get away with it," but there is a better expression—and not be held accountable for that? Are you aware of that?

Chris Hopson: I must admit that I do not recognise that. I do recognise that some complaints, due to the nature of their complexity and because they can involve some really serious issues in relation to the members of staff and their fitness to practise, can flip into disciplinary or employment issues. Because you have a duty of care to your members of staff as well as a duty of care to ensure that you answer the complainant's concerns, my reading is that that is why complaints can get inordinately dragged out. To be honest, as we know anyway, and as you have heard in previous evidence sessions, the PHSO is now significantly increasing the percentage of cases that it is going to investigate. Even if you thought that was the practice in the past, you certainly know that is not the case now. To be frank, every chief executive whom I have come across is trying to do the right thing, and absolutely recognises that they have a duty of care with regard to the complaints of the patients.

Q421 Rosie Cooper: You have not been in Liverpool, then, because one has just gone down the road. Carry on.

Rob Webster: I think the converse is true. I am more aware of people who have said, "This complaint has come into us. We don't have anything do with it, but we will co-ordinate it because we need to get it resolved." The sense is that you do not want to go to the ombudsman because it takes a lot of time and effort, and people, in general, want to come to work to do a good job and get things resolved. You would have to be able to manage the chief executive, the medical director, the director of nursing, all the heads of service, all the clinical directors, the non-executives, who would be looking at this with the quality committee, and the governors, if it is an FT, to say, "We have a culture which railroads this so that it gets booted into the long grass." I think the management time and effort to do that is disproportionate to the time it would take just to sort it out.

Rosie Cooper: I agree generally, but—

Q422 Charlotte Leslie: Can I ask a very quick question? The perspective you have just articulated may be very different from some constituency MPs' perspectives and many complainants' perspectives of what happens. Certainly, from my perspective in dealing with casework, it does feel that things get kicked down the road and as if there is gaming. Why do you think your perspective as the establishment and as representing institutions is so different from the perspective of those who experience it on the ground, and those who deal with those complaints?

Rob Webster: If you are hearing that we are being too positive, then we will have to apologise. We are saying that there is a mix here and things are improving, but not quite in the right place. If you have an episodic set of communications with an organisation, where you might have to wait a few weeks for communications to come back while things are being resolved between different providers, that is where discontent and unhappiness

breed and it may feel like things have gone into the long grass. Often what is happening is that there is a lot of chasing and work going on. In good organisations where they keep people in touch and just say, "We are still on this; there is nothing to tell you at the moment, but we are still on it," you will get more happiness. But in others, where there is not enough communication, either because of resources or because the culture is not right, it might feel as if it has either been booted into the long grass or not been taken seriously.

Chair: Can we move on and ask Grahame to come in?

Q423 Grahame M. Morris: Mr Webster, could you clarify something? Does the NHS Confederation represent any commissioners, or is it exclusively providers?

Rob Webster: No. As part of our organisation, we have an organisation called NHS Clinical Commissioners and more than three quarters of CCGs are members.

Q424 Grahame M. Morris: Okay then, perhaps you are well qualified to answer the question in that case. Earlier, we were talking about the procedures that the providers were encouraged to adopt—best practice and so on. In terms of using the commissioner to make the complaints, what are the circumstances in which that is appropriate, and can that really make a difference over complaining to the provider?

Rob Webster: I think often people can choose to complain either to the commissioner or the provider. Sometimes they might have a complaint against the commissioner.

Q425 Grahame M. Morris: You made the point that the commissioners do not have the same resources to put into the process.

Rob Webster: That is certainly the case, as they did previously, but there may be a treatment that is not available on the NHS and you might want to challenge that through the commissioner and make a complaint about it. You may think that it is better to complain to the commissioner because they have more of an overview of what is going on within the local patch as they are paying for the care, ultimately. People make different choices depending on the issue and their understanding.

Grahame M. Morris: Absolutely.

Chris Hopson: I think certainly our members say that commissioners generally are taking much more of an interest in this area and it is cropping up in conversations more frequently. If you ask us, "What is changing?", one of the things that is changing is that this is coming higher up commissioners' agendas and you are getting conversations that you did not have before.

Q426 Grahame M. Morris: Is it working, though, in your judgment? Are complaints that are routed through the commissioner, which is a new part of the structure or architecture, rather than through the provider, having the desired effect in terms of improving the service and positive feedback, and impacting on the providers to change their practices?

Chris Hopson: It is difficult to identify the particular impact of different routes. All I can really give you is a general picture. Our sense is that we recognised three to five years ago that this was something that we needed to improve. I would argue that over the last couple of years, for a variety of different reasons, it is improving. We think it is improving quite rapidly from a combination of some changes in the framework—such as the CQC inspection regime, the fact that the PHSO is now looking at more cases and a whole bunch of different things—and it is also being driven by individual trusts doing more in this area. On the day that a *Which?* survey comes out showing that, although it is improving, we still only have 25% of complainants being happy with how the NHS handles their complaints, we would be the first to say that we think there is still quite a long way to go, and we would also be the first to say we recognise that there is a degree of variation. The bit that I do not recognise, which is what I thought some of your previous witnesses in this inquiry have said, is that there is no change and that it is just the same as it has always been. That we do not think is reflected in the evidence. We think there is change and that change is happening quite rapidly, but there is still, to be frank, a long way to go, particularly to get consistency right the way across the piece.

Rob Webster: I think commissioners have a really clear role in complaints in general, and, through the quality groups that exist locally where they look at complaints information, incident information and any soft intelligence that they have, they can pinpoint where there are issues in systems; and, because they have a system view and because we operate in a system, they are more likely to be able to seek a resolution sometimes for patients. I think the use of commissioners, both in having complaints as one of the mechanisms for driving change and for resolving complaints, is something that will grow.

Q427 Grahame M. Morris: Are commissioners better placed to spot trends, for example? I will just make one up. A particular provider has a large number of slip-and-trip falls—broken neck of femur. Are they in a position to say, "We as the commissioner are really concerned about this, and are you going to improve this service here?" Is there any evidence that that is happening?

Rob Webster: Boards will have good intelligence around that anyway for their individual organisations, but what commissioners can bring are additional bits of information from elsewhere about the same patients, such as what happened to them downstream after they left the hospital, for example. They can also bring benchmarks from other organisations in different parts of the country. I think being able to see the bigger picture is definitely part of their role.

Grahame M. Morris: Thank you.

Q428 David Tredinnick: With your permission, Chair, I would like to move on to patient advice and liaison services—PALS. Robert Francis, for one, has been very sceptical about the effectiveness of hospital PALS in helping patients wishing to provide feedback about services or to make complaints. In fact he told this Committee last year that, in his view, there should be a more independent and active element to patient advocacy—for instance, assessing a complaint and suggesting a course of action to a patient. How effective, against that background, can PALS really be in supporting patients who have a concern about

their treatment? It is a pretty damning statement from the man who has produced a great report.

Chris Hopson: I recognise that. Our very clear view would be that hospitals can be quite intimidating places and that, if you have a complaint or concern to raise, having a place where you can clearly go, whose job it is to make it clear where you can go, and to give you some initial support in doing that, is very important. That is the role of patient advice and liaison services, and we think they do that job very well. We would then be the first to acknowledge that, if that concern cannot be dealt with and if it then develops into a serious complaint, it is important that the complainant should get access to independent advocacy services and that the PALS service should then pass on that complainant to the independent advocacy service.

Rob was talking earlier about the changes that have been made. One of the things that we are concerned about is the fact that the Independent Complaints Advocacy Service was effectively broken up as a result of the 2012 Act, and each local authority is now responsible for commissioning advocacy services in its local area. It is very clear to us that that is now being done on a patchy and, to be frank, less effective basis. So I completely agree with you that there is a very important role for an independent advocacy service, but, in our view, it sits very happily and appropriately alongside a patient advice and liaison service in a hospital, and it is perfectly possible to have the two working together.

Q429 David Tredinnick: You could argue that the system has been broken up and you could say it has been more localised, but is not the key issue here to what extent the trusts are making use of the feedback provided by the PALS services? What evidence is there that they are making use of it?

Chris Hopson: We would say, as part of this whole kind of change, that that is something that trusts are doing significantly more effectively. I could reel off a series of case studies or provide a note, if you would like one, on a whole range of ways in which hospitals and community ambulance and mental health trusts are all using patient feedback to improve services. I keep coming back to the last visit I did because it is at the top of my mind, but when I visited Hillingdon hospital 10 days ago, they were able to tell me five or six different things they had improved as a result of patient feedback. So it is happening.

Q430 David Tredinnick: Thank you. But is not the reality that PALS—these patient advice and liaison services—are becoming almost part of the trust themselves? They are kind of being sucked in. Is that right?

Chris Hopson: I would not say they are being sucked in. They are a formal—

Q431 David Tredinnick: Mr Webster smiled at that. I don't know whether he wants to comment on what I have said.

Rob Webster: There is a trade-off here—I am just thinking about my PALS services that I have used in the past—between people who understand the organisation and the system that they are in, and people who are independent. You need to appoint great people whose first view is, "How am I going to get this issue sorted for this patient, because there has

been a failure of communication, service or understanding that has led to an issue which we can probably resolve?" PALS resolve the vast majority of issues without them becoming formal complaints and tend to be fairly effective. If you have organisations that look at the four Cs of compliments, complaints, concerns and comments and look at the trends in those and receive their reports quarterly or annually, which they will do, then you can look at the trends. There is always a trade-off between separating something for it to be independent and for it to be connected enough to do its job. I think Chris's points about ICAS, the independent advocacy services, is well made. We must make sure that we are protecting vulnerable patients so that they can be supported to access good advice and resolution of issues when they arise. What we hear from members is that they are concerned about that.

Q432 David Tredinnick: You think the balance is about right, notwithstanding what Robert Francis said, do you?

Rob Webster: I think that PALS, as a service, is not widely understood by the public in the way that, say, PALS might be understood by people who use the service.

Q433 David Tredinnick: Is that because there has been poor or little advertising, it is just another one of these new bodies and no real effort has been made to get across who or what it is, or what it does?

Rob Webster: I think across this whole agenda there is a narrative that plays out in public which is different from the facts. It is not to say that there are not issues that need to be resolved, but there is a narrative that plays out in public which is different from the facts and there is a journey we are on which requires us to work with the public and engage them in ways which help us to explain to them, just as the CQC said, what their rights are, and where they go if they want to get some information about services, some resolution of issues that they have had and to make sure that their concerns are addressed.

Q434 David Tredinnick: Did you know that Healthwatch bills itself as a consumer champion?

Rob Webster: I do know that.

Q435 David Tredinnick: Do you think they have achieved that objective?

Rob Webster: It is very difficult for any organisation when it is just over a year old and it is trying to work in this environment to do that. We have good examples from local Healthwatch, where they have been focusing on the right kinds of areas, and national Healthwatch I think made some announcements. It can be stronger, and I think we have to try and give the system a chance to mature and work.

David Tredinnick: Thank you very much.

Q436 Chair: Could I carry on a bit further into the independent advocacy services, because it was one of our recommendations last time round that that should be strengthened? Do you agree with the recommendations in the Clwyd-Hart review and some of the points they make that ICAS providers should be obliged to use a single brand, because there is this variation in the degree of local support, but also different branding for it? If people do not know what PALS is, they are even less likely to know what ICAS is because it is different branding across the country. Presumably you have seen their recommendations. Would you agree with their recommendations, or do you feel there are points that should be added into that?

Rob Webster: I would make two comments really. The first is that we need to have sufficient capacity to meet the needs of people who require advocacy services. The second is that people need to trust them. You are looking at vulnerable people, often with mental health issues, who require a degree of trust in something which is going to see them through some tricky times. If having some kind of kitemark or branding helps build capacity and trust, I would support it.

Chris Hopson: For me, the consistent branding and provision of the service seem to be very important. It is not a particularly well-known brand. In fact, it is a very little known brand, and I think we have a nervousness that the shift to local authority commissioning of those advisory services on a local authority by local authority basis, with some people having used Healthwatch and other people having used different things—and, to be frank, with other people, it is not entirely clear what they have done—is creating a patchwork approach to this, which I have to say I think we are really quite nervous about.

Chair: Thank you. We will move on now to Charlotte. You were going to talk about the treatment of staff raising concerns.

Q437 Charlotte Leslie: Yes. PIDA—the Public Interest Disclosure Act—is designed to ensure that staff can raise certain concerns to designated bodies outside an organisation without fear of reprisal. If an NHS employee has to rely on PIDA to raise a concern, doesn't that indicate that there is a failure in the organisation?

Rob Webster: Can I just say something about where we think we are on this in general? There are something like 1.4 million incidents reported in the NHS each year by staff. The vast majority of those are no harm, but some of them are harm-based and some are serious harms. 96% of staff say that they will report an incident. The majority of staff—well over 80%—say that they are encouraged by their organisation to report incidents, and the vast majority of them feel safe in doing so. But there are cases where people feel unsafe—there are too many people who feel unsafe—and they require some protection. Dean probably has something to add here around the employment side of that.

Dean Royles: It is the point that Rob made really: there is a difference between raising concerns, which many staff do every day, and blowing the whistle outside the organisation, which PIDA would protect them from. Part of the debate has become confused, in that we sometimes say whistleblowing when we mean raising concerns, and we sometimes say raising concerns when we mean whistleblowing, but we know from all the surveys that come out that something like 90% of staff know how to raise a concern; the vast majority of them feel safe to do so; staff say they are encouraged in their organisations to raise concerns.

We are not particularly good at getting back to staff when they do raise concerns. If we look at the staff survey results, for example, something like 54% of people say that people do not get back to them, and I think that is the area we have to focus on, but it is about the raising a concern issue rather than the whistleblowing issue. If we can get better at that, then we will stop the need for staff to raise concerns outside the organisation, and, more importantly, there will be some staff in organisations who have concerns, but when you do not get back to them, they just do not say anything, and that to us is just as damaging for patient care. We have to get better at getting back to people when they raise concerns, but we have to avoid the confusion between staff not feeling able to raise concerns and what sometimes gets referred to as whistleblowing.

Chris Hopson: Doesn't this require a nuanced answer rather than a black and white one? There clearly are some cases where, to be frank, it is a failure and where the individual member of staff feels they have raised the concern, it has not been addressed properly and the board is not responding in the way that it should. There are clearly some cases where it is a failure. Equally, it is very clear that there are other cases where there is a significant amount of complexity and nuance around the case, and where, for example, you might have two members of a team who are not seeing eye to eye, where one of the ways in which the argument is carried on is through making respective protected disclosures. All I am saying is that I think we need to be careful about recognising that. What our members most say to us about whistleblowing is that there is usually quite a lot more complexity and nuance in this debate than you might necessarily see and read in some of the public debate around it.

Q438 Charlotte Leslie: There are cases, as you say, where there is much more nuance than a newspaper might want to suggest, but what can also happen is that a case can be raised where there is not a nuance, where it is fairly black and white, and there seems to be a whole orchestrated organisation to make it seem very quickly that it is more nuanced than you would like to think. Dr So-and-So raises this concern and, before you know where you are, people start sucking their teeth saying, "Of course, Dr So-and-So had this problem with anger management." Then you find that he wasn't very good to one of the staff, and, before you know where you are, a whole lot of complaints have come out about Dr So-and-So, who had had an unblemished record thus far. A lot of the nuance seems to be created after the black and white issue is raised. I know that things are improving, but I wonder why the answers you have given seem so very different from the world in which many people exist on the ground. Of course, I know as an MP that no one ever comes to you when things have gone well, only when things have gone badly, but there does seem to me to be a slight asymmetry between the reality that we all experience and what you have just described.

Chris Hopson: I do not think there is such an asymmetry in the way that you describe. We would recognise that you, as Members of Parliament, are quite often on the end of perfectly legitimate complaints, some of which, to be frank, are egregious and where something appalling has happened. We would recognise that, in a system like the NHS, there are bound to be a significant number of examples where something has gone seriously wrong and where, to be frank, the organisation has not dealt with it properly. The point we are trying to make to you—in a sense, you have already made it for us—is that you tend to be on the end of a relatively small number of what, quite frankly, often get to be well-publicised cases. The point we are trying to make is that that is not reflective of

the overall quality of care that is provided, or of the fact that, as I think you said, we are getting better, but there is still some way to go. I do not think there is quite the degree of asymmetry that you were implying. That would be my response.

Rob Webster: I think it is a great point in terms of how we support staff and protect patients. What our members need are the tools to do that. Every issue that gets raised will end up being something to do with staff. There will be a complaint about something that somebody has done. Dean, you probably have some insights here which are worth sharing.

Dean Royles: I was going to agree with you in the sense that part of the issue is that, when people raise concerns, it is not raised in a vacuum. You are raising a concern within the organisation and it is often about somebody else. Very rarely does care happen in isolation. Consequently, all the other staff are protected by those employment law issues that Rosie mentioned earlier—about whether the staff are supported by HR, for example, and whether that gives a free and open culture coming through. Staff are protected in the NHS by employment law, just as in other sectors, and we have ACAS codes of practice that we need to follow. It is a complex issue that we have coming in. The majority of concerns that get raised in the organisation get resolved in the organisation. Some people do not feel that is the case; some people will be right about that and then feel the need to raise it outside the organisation as well.

Q439 Charlotte Leslie: I want to concentrate on what you say is the relative minority of cases where things have gone wrong. In many ways, a system is only as good as its worst-case scenarios. If we want to move, as Robert Francis said, to a culture where it is harder not to raise a concern than it is to raise a concern, how, in the current climate, can we do it? If you are the head of a trust and you have a concern with making your trust look good—perhaps finances depend on it—there are a lot of incentives and drivers to cover up bad news. I cannot see any tangible incentives and drivers to come out with bad news. How can we convince people who may need to raise a concern in the future, in an organisation where raising concerns has not had a happy history, that those at the very top of management are going to be incentivised, possibly by sticks as well as carrots, to not bury bad news and to take the complaints on the chin and act on them? We have not seen that so far.

Rob Webster: Let us go back. The generality is different from that, isn't it? The generality is one and a half million incidents raised by staff—some of them serious harms, some of them moderate, the majority minor or no harm. So we are in a culture where the generality is that people do raise incidents and concerns every day, and the vast majority of staff know how do it, do it and feel that they are encouraged by their organisation to do it. Chris, Dean and I could point you to trusts that have reported themselves to the CQC—have gone public on a failure which has meant that they had to recall a load of patients. What everybody understands is that you have to do the right thing, because doing the right thing will see you right in the medium term.

What I recognise from what you say is that we operate in an environment where, sometimes, the consequences of doing the right thing are that you are criticised, lambasted or it is made out that you might be the issue, when often, if there has been a failing, it might be to do with the system or an event, or it might be your fault. But we should start with, "What has gone on in the system? Has there been an event or is it your fault?", rather than presuming that it is. Many of our members probably feel that, often, the culture we

have been in has been one of, "Let us attack the person first," rather than looking at the root cause of the issue.

Chris Hopson: Also, we are in that changing strategic framework as well, aren't we? We now have a CQC inspection regime where trusts will be inspected in a very different way about whether they are meeting these requirements. Without for one moment being party political—because that is not what our organisation is like—you also have to acknowledge that what the Secretary of State has done in his personal leadership of the NHS over the last couple of years, really focusing on these issues and launching patient safety campaigns, has had an impact as well, in terms of people realising that there is a real importance, a real need to change around getting these issues right.

I see a combination of two things. One is absolutely what Rob is talking about, which is trusts wanting to get it right and genuinely improving their performance here, but also then, absolutely as you would expect, more of a top-down, "We are creating a strategic framework in which that can be measured and in which there is a combination of both sticks and carrots."

Q440 Charlotte Leslie: Very quickly, because I have taken up a lot of my time, one of the problems is that, because there has not been accountability for people at the very top of the system who have been demonstrated to have covered up concerns that they should have acted upon, going back into the system—whether it be through setting up reputation management consultancies, or whatever it might be. There are people floating around the system who were part of the problem in a very big way who were never held accountable, and there are a significant number of people who have historical cases of trying to have done the right thing who now do not have a job at all. That is the tangible precedent that is still set. How can we encourage people to raise concerns and managers to accept those concerns, when we have people who have got away scot-free with covering up those concerns, and people who raise them now having no jobs and in one case suffering from cancer, and they cannot get any support for doing the right thing? How can we really use that as a categorical imperative to change a culture?

Rob Webster: What we always have to do is reinforce where people have done the right thing.

Q441 Charlotte Leslie: But we are not, we have not and we have not historically done so. We still have a significant number of whistleblowers who have no income, who have completely sacrificed their family, and in many cases their friends and their entire career, because they have saved patient lives; and we have managers—individuals like Cynthia Bower, who certainly did not do that—who are still making a very nice packet, thank you very much. What kind of precedent does that set for anyone who wants to do the right thing? We can sit here having very nice words about how everything is quite good and most people are fine, but, while that significant precedent is there, how can we seriously talk about changing the culture?

Rob Webster: The precedent I would like to offer as an alternative is to look at someone like Helene Donnelly, whom I know you have had here, as somebody who did whistleblow in Mid Staffordshire, who was discovered by her chief executive to be

working in his organisation, and he immediately said, "Come and work for me and be the independent person in the organisation who is going to help change the culture." That is now being replicated in other organisations, and it is no accident that Helene was one of the main speakers at our conference, which is the biggest conference for NHS leaders. We want to say that doing the right thing pays off in the medium term, and I think the Robert Francis review around whistleblowing, which we welcome, says, "Let us look at what has actually happened to the people who have been involved on both sides. Let us get both their sets of stories and learn the lessons." What we cannot do is have a narrative that says, "If you do the right thing, it will cost you your job and livelihood."

Q442 Charlotte Leslie: I agree. Is there any way that we can set up what I have termed a "white list" in a more formalised way so that, if someone is shown—I know it is complex—to have raised a concern and been vindicated in their concern, and perhaps dismissed from their job, there is some kind of formalisation whereby we can monitor which organisations re-employ those individuals as a proxy for demonstrating that those organisations are ones that take independent scrutiny and transparency seriously? Is there any way we can formalise this so that we can scrutinise which are the pro-transparency organisations and which are not by using re-employment of whistleblowers as a kind of proxy?

Chris Hopson: My sense would be that we need to be careful about saying to individual trusts, "Your employment decisions about who you should employ are based upon whether the individual sits on a white list or not." To be frank, employers need to make decisions based on a range of different criteria, but I completely accept your argument that we should find a way of identifying and celebrating those organisations that are appropriately transparent.

The bit that I have a slight issue with is the sense that people are not accountable. In a general sense, we could tell you—and I do not particularly want to rehearse them here—the names of a significant number of chairs, chief executives, non-executive directors and executive directors who over the last two years, as a result of failures of care inside their organisation or other failures, are no longer in position. I do not entirely recognise the description that senior leaders are not accountable, because there clearly is a turnover of senior leaders in organisations where there have been failures.

Chair: I am very conscious that we are nearly half an hour late for our next panel. David, I know, wants to ask a very quick question and then, Rosie, I am coming to you.

Q443 David Tredinnick: Just running on from Charlotte Leslie's passionate point about the fate of whistleblowers and some of the casualties—the people who have given up their career to bring to light things that have been wrong—do you think there should be some more proactive mechanism to help people back into work within the health service? Does it not reflect very badly on the service that there are these stories about people who have been brave enough to come out and shout it from the rooftops? Should we not be doing something for them?

Dean Royles: This is one of the challenges around this debate. I am really aware that this is a very live issue and, if you talk about some of the context of it, it can look as if you are

in denial. We have all tried to say here that we recognise there are some issues, but if the Committee wants to look at some real areas where we could make improvements, there is something about understanding that the context in which the NHS works is that sort of systemic context. The way that Parliament scrutinises, that regulators regulate and inspectors inspect, plays its part in the culture that is set within the organisation. There is an overall view that we have to get right about getting the culture right within the organisation. If we get that right, people will feel freer to be more open about the sorts of issues that we have within the organisation.

Then we have this issue where people are raising concerns internally in the organisation, and if we can get more of those things right we prevent whistleblowers from needing to come to the surface in the first place. I think we can get that right by getting better at getting back to people when they do raise concerns, to reassure them, and that might be some sort of composite information, it might be individual information, but it is also about the processes and procedures that NHS organisations have to work under. If you look at something like "Maintaining High Professional Standards," which is the doctors' disciplinary procedure, it is tortuous, legally bound and complex, such that as soon as an issue involving a doctor comes to light everyone runs for the lawyers to try and get it right in the first place. That is not the right way of resolving the issue or setting the culture in the organisation so that people feel free to raise concerns. If we can get those sorts of things—those thousands—right in the organisation, then we will get a much better culture.

Chris Hopson: I think there is also a chance to use the Robert Francis review of whistleblowers to answer the question that has just been asked as well, so we welcome the review and think there is an opportunity there. I recognise what both Charlotte and David have said—that there are some issues around supporting whistleblowers, and that is precisely one of the reasons why the Secretary of State announced the review.

Q444 Rosie Cooper: I am hoping that I will be able to give Robert Francis the evidence that I have currently. I am going to wrap up in my session a number of questions that I had to ask, so I will probably just bowl them all at you and some of it will be difficult. Healthcare professionals have a duty and professional responsibility to raise concerns about care quality and patient safety with their employer. My first question is what do you feel the corresponding duties of the NHS as an employer and the trust board are in this instance? What is your view of a trust board that believes that they are there representing the community and, therefore, are insulated and divorced from the mistakes and errors of the executive, not engaging at that level at all?

You talked about accountability, and the question I would put to you is, "Really? Accountable?" Describe to me how. LCH was using HR to threaten and bully the staff: if they did not do x or y, their own employment would be threatened. There was a culture where people were encouraged to make up or fix evidence against their colleagues, be it in a capability way or a general way, so that they could be disciplined and taken out of the organisation. All of that has gone on. That is a fact and it will be evidenced very soon. I put a question to the Prime Minister and asked for a forensic, historical look at investigation into the HR practices of Liverpool Community Health Trust, or any organisation where there were huge concerns, and asked whether he would agree to it. In good faith—and I thank him for it—he said yes. The problem is he then said that the CQC would do it. They have no power to

do it. The reality is that NHS organisations are operating like private companies with public money and doing as they will. They are getting away with bullying and using HR practice, and there isn't anybody to investigate other than the well-led domain of the CQC, which failed dramatically.

I would like you to answer those bits individually, but Rob, much as I respect the panel, you said the narrative is different from the facts. My big question out of all of that is, if I have uncovered in eight months' work all that I have, how much more of this is out there, and how much are you really fooling yourselves? That is the huge question.

Rob Webster: The narrative being different from the facts, I think, was about raising concerns. The RCN ran a session at their congress called "How to raise concerns and keep your job." Yet what we see is one and a half million incidents raised by staff each year and staff feeling that they are encouraged to raise concerns. That is the difference. I am not going to comment on Liverpool Community Health Trust because I am not aware of those issues and whether any of them are in the public domain either.

Q445 Rosie Cooper: You will be. Most of the things I am saying here are in the public domain. They are either in the CQC report, the ACAS report or HR. The stuff in Parliament is a matter of record, and I am currently hoping that this whole case will be written up and will end up as a major case study. We have lost the HR director, the chief exec and the nursing director. These people used the threat of the NMC against junior staff. "If you don't do this or you don't resign, we will report you to the NMC." This is wicked, wicked behaviour carried on in the name of the NHS. Forgive me, you are sat here now almost—I know you are not justifying it—putting a nice face on that, and it is awful.

Chris Hopson: No, I do not think we are justifying it. I am in the same place as Rob. I cannot comment on the individual case. The bit that I can absolutely comment on is that, if there has been a serious failure inside an organisation, it will be picked up in one of three ways. It will be picked up through a CQC inspection, through the relationship with the commissioner, or it will be picked up in the relationship through either Monitor or the TDA. All I am saying is that I recognise that that has perhaps not been as effective as it ought to have been going back in time. We are saying we are now in a system where we have a number of trusts that have been put into special measures, and what then happens, if improvement is not made, is that there is the ability of the system to—

Q446 Rosie Cooper: Chris, stop. The question is, how do you know it is not happening today in other places? I am not being rude and I hear what you are saying, but the truth is that in July last year LCH got a glowing report. The TDA had it fast-tracked to be a foundation trust. Monitor was already in there. If my dad had not fallen ill, this would never have happened. When I was not happy as a former chair, I started to investigate and I saw stuff. I have uncovered this lot. If I have uncovered this lot—forgive me—telling me that the system will find this out won't wash.

Rob Webster: We are definitely in a better place, aren't we? But there is a lot more to do. If you look at the staff survey and the results around bullying, they are not good enough. If you look at the staff survey, 10% of staff do not feel safe to raise concerns, and that is not good enough. We need to be addressing these cultural issues. What I think you are

pinpointing very well is that it is not regulation on its own that is going to sort this; it is a cultural issue. It comes back to, "Where is the board? How is it being supported to raise the right kind of culture within the organisation? How does the system support that?" One of the big benefits, I think, which is not always utilised but needs to be, around foundation trusts is that they are accountable to their members, and their members are members of the public. Where organisations do this well, where they have 10,000, 15,000 or 20,000 members, these issues come to light. What we have to do is make the most of that.

Q447 Rosie Cooper: Can I make a final point? The staff survey here—you have spoken about the staff survey—was appalling. Picker reported, but it was changed before it was fed back. It was not fed back in its entirety; it was fed back in bits, and part of it was changed. The board version is vastly different from the one that Picker did. When you have dishonesty at that level, where can you go?

Chris Hopson: As I said, it is very difficult to comment on an individual case.

Q448 Rosie Cooper: Let's call it Fred Bloggs Trust. How, when somebody is prepared to do that, can you get through it?

Chris Hopson: As I understand it, the staff survey results are published formally externally, so they are open to scrutiny. All I am saying is that there are a number of accountability mechanisms in place. I cannot comment on the individual trust, but there have been a whole number of instances where, as I said, boards have been held to account for not providing an appropriate quality of care. We have a special measures regime, and, as I have said, chairs and chief executives have moved on.

Q449 Chair: But presumably, where there are 10% of staff saying they do not feel safe to raise concerns, that should trigger some graver concerns about the performance of the board.

Chris Hopson: Clearly, what happens is that the CQC plays a key role in suggesting that a trust should go into special measures, and they will look at a wide range of data, one of which absolutely is the staff survey. Again, just to make the point about complaints, one of the things they have now absolutely upped, in terms of the evidence that they look at, is about the level and the nature of those complaints; that is done in a way that they did not do before.

Q450 Chair: I am very conscious that our next panel is waiting, but I know you want to come in with one final point, Mr Royles.

Dean Royles: I was going to follow up on Rob's point about the cultural aspect in terms of getting it right. In Rosie's case or these cases, whatever we do to restore the confidence that the public and staff have in the system has to be a stepping stone towards getting that culture right within the organisation, so that the organisation that is able to recruit and train some of the best staff in the world, to deliver some of the best care in the world,

when it goes wrong, can be trusted to put that right. Anything that we do has to get that right in the longer term.

Rosie Cooper: I am passionate about the NHS. It has great staff and we need to enable them, not frustrate them.

Chair: Thank you very much. We will end on that point. I am sorry we have kept you a lot longer than we were expecting. Thank you for your patience.

Witnesses: **Dr Daniel Poulter MP**, Parliamentary Under-Secretary of State for Health, Department of Health, **Jane Cummings**, Chief Nursing Officer for England, NHS England, and **Neil Churchill**, Director, NHS England, Improving Patient Experience, gave evidence

Q450 Chair: Thank you very much. First of all, apologies for keeping you waiting; thank you for your patience. Could I ask you to introduce yourselves, maybe starting with you, Mr Churchill?

Neil Churchill: Yes, hello. I am Neil Churchill, Director of Patient Experience at NHS England.

Dr Poulter: I am Dr Daniel Poulter. I am the Parliamentary Under-Secretary of State for Health.

Jane Cummings: Hello. I am Jane Cummings. I am the Chief Nursing Officer.

Q451 Chair: Thank you very much. To start immediately, the Department has told us that you want to complete your programme of work on reforms to the complaints system by March 2015. Could you set out where you are in that programme, whether you are on track, and which areas cause you the most concern?

Dr Poulter: In response to the Francis inquiry, the further work that was done by the Clwyd-Hart review and a number of issues that were raised historically by this Committee, there have been a number of areas that we wanted to look at to make sure that there were improvements made in the complaints system. There are a number of pieces of work that are nearing completion already, in particular about how we make patients much more aware of how to raise complaints. This has historically been an area of complexity, and we are looking at fairly soon publishing a bedside guide, if you like—an addendum to the NHS Constitution—about how we can help patients to better understand and navigate the system in a much simpler way.

There is also ongoing work particularly about how we get greater transparency in the complaints process—for example, how we collect complaints data—and there is a role for the Health and Social Care Information Centre in that, to make sure that we can be in a position to transparently compare where complaints are higher and lower, and compare different healthcare providers.

Q452 Chair: Thank you. Perhaps I could reflect back a question I raised with the earlier panel about complaints within primary care. Do you have any plans to reform the currently fragmented system, in which complaints that arise in one local area may be handled at some distance? In my area, for example, the complaints from the south-west are handled in north London.

Dr Poulter: There is a key role in this for the commissioner of services. As we know, NHS England has a key role in that, and Neil, I am sure, will want to comment on that.

As you just heard from the previous panel, there is an enhanced role in terms of safeguarding the primary care system through the new role of the chief inspector of GPs, and the role that the CQC has generally in safeguarding patients' interests and making sure that complaints are properly listened to, but there is also a key role for the commissioner of services to make sure that there is a more joined-up approach to complaints. For example, NHS England has also set up and oversees at a local level quality surveillance groups, which are particularly focused on the provider sector, but that is about making sure that that picks up on some of the intelligence about how the system is working.

Q453 Chair: The trouble with calling it a "bedside guide," of course, is that patients in primary care are not in beds. Will it actually refer to helping patients across the NHS?

Dr Poulter: Absolutely, and I was perhaps being a hospital doctor in my reply to you there and focusing on the fact that we often think, incorrectly, of things just being through the prism of the hospital sector.

Chair: Of course, 90% of contacts happen in primary care.

Dr Poulter: Primary care is a significant location for contact. It is, if you like, an easier guide for patients to understand.

Q454 Chair: It will guide people as to whether they should complain to a commissioner or a provider, and will provide a single, one-stop guide where they can be shown how to complain.

Dr Poulter: That is right. It is about making patients feel much more empowered to raise concerns, wherever that is appropriate, because sometimes patients are concerned or have issues or worries about raising concerns. It is making it much clearer that this is not something that they should be afraid of, and is also clearer about the routes—either to provider or commissioner.

Q455 Chair: But in order to produce that kind of guide, you have to have been very clear about what the reforms to the system are, and those reforms have to be in place. That was the original question: how far on in that process are you, and are you behind in any of the schedules that you have set out?

Dr Poulter: No. I think we are anticipating that we will meet the 2015 programme. I have already seen a draft of this bedside guidance recently myself, and we are making sure that

we get into, if you like, a better place on that, so that it is simple and easy for patients to understand—it is not complex—how to raise complaints and concerns. Also, there is going to be a simple flow diagram of how to do things. In the complaints system, historically, there has been a concern raised that some people know how to complain—some people are quite tenacious when they raise concerns—but other people do not know how to go about it. It is about making very clear that it is something that is a completely normal and acceptable part of being a patient. If you are concerned and not happy, it is good for the health service to hear where things can be done better in the future. Secondly, it is about very clearly laying out how the complaints process works. I think it will be very beneficial, and the plan will be to disseminate that widely.

Q456 Chair: Thank you. I know, Mr Churchill, you wanted to come in.

Neil Churchill: Yes, just to answer your question about how NHS England works in terms of local resolution versus centralised resolution. I am really pleased that you are raising the issue about complaints in primary care, because one of the things we have been seeking to do is to make sure there is a single NHS response and programme to improve complaint management. It is not just focusing on hospitals; it is focusing on hospitals and primary care settings.

Q457 Chair: A serious concern about the way this happens has been raised with my CCG.

Neil Churchill: When NHS England was established, we did not have the capacity to deal with the volume of complaints and concerns that were coming in. One of the things we had to do was put in place some extra capacity quite quickly. What happened there is that different regions did that in different ways. Some area teams brought it in-house; some area teams use the commissioning support units to provide it. We do have more centralised functions in some localities than in others, but there is still local resolution. For example, the area team directors will sign off complaints even if they have been co-ordinated by the CSU on their behalf. They still see them and sign them off, but now that we are over a year in and we have stabilised the system and performance is significantly improved, we are in a position to review that arrangement and see what has been working well and where, and why it has been working and, crucially, to look at what patients are saying. One of the things we have been trying to do is really understand people's satisfaction with the process and their willingness to recommend it to others where we have seen significant improvement over the year, but we will look at how it is working in different places where we have different arrangements, what the pros and the cons of those arrangements are, and make sure that we learn going forward.

Q458 Chair: Clearly, the feedback I am getting is that it is not working well, and that having complaints handled at some distance from local areas does not allow sufficient feedback into the system.

Neil Churchill: It would be good to see that feedback, if you are able to share it; then I can field that into the review.

Q459 David Tredinnick: Minister, in the last session we heard about what I might describe as a complaints fog: patients really don't know where to go to make their complaints now because of all the changes in the structure. One of your proposed initiatives is to put up notices in hospital wards. Could you start by saying what progress you have made with that simple initiative, please?

Dr Poulter: That was the issue I was just referring to the Chair of the Committee. We are looking at putting in place a very simple, as I put it, bedside guide or a complaints guide for patients which much more easily directs people on where and how to complain, and facilitates access to the system for people who may not understand how to do so otherwise. That is something that will be disseminated across the NHS.

Q460 David Tredinnick: Fine. I may have missed that when I was looking at my notes just now, but in the Army, which I served in very many years ago, if the general in charge wanted a notice put up in a barrack room, it would happen the next day. I cannot really understand why it takes so long to put a simple notice up in a ward that belongs to the health service. You have just said that you can have notices by the beds, but is it not very straightforward to put a notice up on the doors? I cannot understand how it can take so long for this to happen.

Dr Poulter: Part of the process was that we wanted to engage, work out and understand from the Clwyd-Hart review, and also from further engagement, what people felt some of the barriers were to raising complaints. Then some guidance and a complaints pro forma, if you like, was drawn up. My initial impression of the first draft that I saw was that it was not giving us the simplicity that was required, so we have now gone back to make sure that it is in a better place. There is something that will be coming forward, I would imagine, over the next three to four weeks, or certainly by the end of the summer.

Q461 David Tredinnick: That is very helpful; thank you. Going on from that, could you comment on the number of outcomes that HMG—Her Majesty's Government—"wants to see" from its complaint reform programme? We have a list of different issues, but could you perhaps give us the priorities here?

Dr Poulter: I tried to focus earlier on some of the clear priorities.

David Tredinnick: Some of these questions inevitably overlap.

Dr Poulter: Indeed. One of the things we have focused on, as the gentleman from the Foundation Trust Network highlighted a moment ago, was how we can drive and improve quality of care and responsiveness in the NHS through greater transparency. One of the other key pieces of work that is going on at the moment is how we collate the right data and information about complaints, how we look to be open and transparent, and how we can potentially publish that, so that we can compare different healthcare providers. That, as well as the simple support for patients, is one of the other key ingredients of the ongoing work that is going to come forward in 2015.

David Tredinnick: Thank you very much.

Chair: Rosie, you are going to bring us on to the area of patient advice and liaison and advocacy services.

Q462 Rosie Cooper: Right. I was not sure we were going to do it because of the time pressure. The Department is to lead a review of PALS services within the NHS. What options do you envisage for the future of PALS services?

Dr Poulter: We are all aware—I believe I was on the Committee when this question was last considered, but correct me if I am wrong, and I think the Committee at the time made a very valid point about this—that there is variability in PALS services. There was a discussion about whether being based within the healthcare provider was the right home for PALS services, or if PALS could be as effective as it needs to be, but the view that the Committee came to last time, I believe, and the view that we support, is that there is a benefit from a PALS service: there is a go-to point for patients and their families when they have immediate concerns, and that can be very helpful as an initial point of support and contact. I think there is an issue about how we reduce some of the variability in PALS services and how that can be taken forward. The increased scrutiny that is coming on to the complaints process in hospitals that is offered by the CQC process of inspection—I know Sir Mike Richards outlined it to the Committee when he was here—would be very helpful in encouraging a more positive approach in those PALS services that perhaps needed improvement in the past.

Q463 Rosie Cooper: In 2011—you are quite right—the Committee recommended that managers in the NHS should increase awareness of independent advocacy services and should require PALS to refer serious cases to an independent organisation speedily, quickly, to reduce delays in the process. Are you going to look at that? For many people, there is at the bottom end very little difference between PALS and a volunteer on the door saying, "Yes, that's a problem, but we will do this and go that way and we will fix the TV," to somebody who is really dealing with what is the beginnings of quite a complex complaint that they may not directly handle, and it all gets involved within the trust.

Dr Poulter: There are two or three things here. First, there is the issue about how we create the right atmosphere and culture as best we can in all trusts. I believe the friends and family test that has been introduced to acute care settings and maternity is a very positive step forward in getting a routine approach from most hospitals to understanding what patient feedback is all about, and understanding that just listening to small things can make a big difference in terms of the culture. So that helps to embed in hospitals that essential focus. It is not just about good outcomes; it is about good experience of care. Getting that in place in the first place is a big and important step forward. That is, as we know, being rolled out to primary care and other care settings as time—*[Interruption.]* No, indeed, but I think it is important to set in that context. A lot of what this Committee talks about is cultural change and getting the right culture in place in a responsive trust.

Q464 Chair: It was a very specific question about the more serious complaints, I think.

Dr Poulter: Indeed.

Q465 Rosie Cooper: Absolutely, and compared with independent advocacy.

Dr Poulter: We come back to the issue that we were talking about with the Chair and also with David about giving patients a much better understanding at the bedside about how and where support is available early on. What we tend to find, I think, is that, where we hear about very difficult complaints, which are very distressing for patients, it is often the case that there have been a number of factors involved. There was perhaps a problem with the ambulance, a problem at the hospital, or there may have been a problem with the GP referral. There may have been a number of issues put together.

Q466 Rosie Cooper: How is PALS going to sort that lot out?

Dr Poulter: I think what the PALS service can do—if we can signpost people much more effectively to a PALS service earlier on—is help people understand how and where further support may be available.

Q467 Rosie Cooper: Minister, you are not saying a patient advice and liaison person could sort that out.

Dr Poulter: No, but I think there is a role for those people in helping people get to that sort of support and help more quickly.

Q468 Rosie Cooper: Do you agree that they should be directed to an independent advocacy organisation?

Dr Poulter: If there is a complex complaint, there may well be a role for an independent advocacy organisation.

Q469 Rosie Cooper: It is only if it is really complex. Anything else is not. Who judges?

Dr Poulter: You have to take a view on everything case by case, as you do with everything else.

Q470 Chair: Minister, if you are setting out a patients' guide, at what point in that process do they get signposted? We were recommending that at an earlier stage serious complaints should be picked out and directed towards independent complaints advocacy. Now, that system has become rather fragmented because it is being commissioned locally, and we heard from our earlier panel that it is very patchy. If you are going to be producing a guide, what is going to be in that guide about where, at what point and which patients get early signposting with serious complaints? Would that sum it up, would you say, Rosie?

Rosie Cooper: That is absolutely spot-on. Some people think PALS services are either really good at dealing with minor complaints or a waste of space. For complex stuff people should be encouraged to be directed.

Chair: What is your view on that and when is it going to happen?

Dr Poulter: That is a very valid concern. It is impossible to have a blanket approach across all of them, and I think it is important to get people to the right help, where appropriate, as quickly as possible. There is clearly a role in that as well for the commissioners and how the commissioners set up the arrangements. I think Jane wanted to make a couple of points on that.

Jane Cummings: I was going to add to what the Minister said, in that the supplement that is part of the constitution to which the Minister has referred describes going to providers—going to a commissioner. It helps people understand what type of commissioner is responsible for which service, which picks up concerns earlier. It also identifies what patients or people complaining can expect to get, so there is a bit of expectation-setting—"This is what we think you should receive"—and it provides them with information about the various different options that are available, whether that is local Healthwatch, a PALS service or an advocacy service. If patients have a complex complaint which is serious, they want to feel listened to, to feel that there is somebody who is responsive and supporting them in the resolution of that complaint. Pointing to the ability of the person receiving the complaint, whether that is the commissioner or the provider, and, alongside that, information that they can use to be able to see what is available, is absolutely critical. I would agree that having somebody who is an independent advocate is the way to go.

Q471 Chair: If we take the very sad case, highlighted by the ombudsman, of Sam Morrish, it is the cases that are serious and that cross several boundaries, where there are several organisations that have let people down, and having someone who is going to hold the whole case with responsibility. Within your booklet, how are you going to set out how people can early on be recognised and picked up as needing somebody senior to hold responsibility for their case across all the different pathways?

Dr Poulter: That is the role of having, as I call it, the bedside guide or, if you like, the guidance there available to a patient as they may run into difficulties, and trying to have early signposting about what their type of complaint may mean. The tension here, of course—and we are absolutely trying to avoid overcomplicating that guidance—is that, in trying to account for every scenario, you end up making it not easy for a patient to understand.

Q472 Chair: But are you going to have that provision in place? We have heard that the provision of advocacy is very patchy. Are you addressing that in your review of the complaints process? Are we going to see at the end of this process that somebody is taking responsibility for serious and complex cases?

Dr Poulter: Yes. We are looking at a number of aspects of the complaints process, but specifically on advocacy services, with a complex complaint very often it is those sorts of complaints that will sit on the desks of the people and the Members of Parliament in this room, potentially, because of the complexity. If it comes to a Member of Parliament to deal with, actually it means that something has gone wrong.

Q473 Chair: But I am asking what you are going to be putting in place to address those.

Dr Poulter: There is, as we know, a responsibility now for local authorities specifically to support advocacy services, and very often with the complex complaints it may well be that it is not just about the health service; it may be across health and care services. There is a duty on local authorities to provide adequate provision.

Q474 Rosie Cooper: If I may, Minister, can I quickly make it very simple for you? Other than for the simplest problems, would you be prepared to say that PALS should offer the help of an independent advocacy organisation, or at least signpost people to it, should they wish to use it? That is a really simple one—a yes or a no, please.

Dr Poulter: If a PALS service is engaged, there is a role for the PALS service to support people in the appropriate way. They will want to make people aware of what additional support may be available to them. That may be an advocacy service, and that is a view that would need to be taken in conjunction and talking with the person concerned and looking at the case. There is no one blanket approach to how you deal with complaints.

Q475 Rosie Cooper: But if somebody has a complaint and goes to a PALS and it is other than the simplest thing, then, on the schedule or the menu of options available to them, what is the problem in pointing out the fact that there is independent advocacy?

Dr Poulter: There is not a problem in pointing that out.

Q476 Rosie Cooper: So would you encourage that?

Dr Poulter: Where appropriate, it is absolutely the right thing to do, and I said that earlier.

Q477 Rosie Cooper: What is "where appropriate"? You are putting in layers and making it complicated. It is very simple.

Dr Poulter: There is not one way of dealing with a complaints process. The complaints that you were driving at earlier are the more complex complaints processes. I would, of course, expect in a more complex complaints process for people's attention to be drawn towards additional help and support, and the services that you have described. That would seem to be a logical thing for a PALS service to do in those more complex complaints. But it would need to be done on a case-by-case basis.

Rosie Cooper: I surrender. All I needed was a "Yes, we will do it."

Q478 Chair: Mr Churchill, I know you wanted to come in.

Neil Churchill: I visited the Healthwatch advocacy in Merseyside recently, and they really pressed on me the importance that advocacy has for vulnerable patients as well as for complex cases. It is certainly true that vulnerable patients are less likely to complain unless they have access to advocates, and that is another dimension to it. If you come

through to the NHS England contact centre, we are able to find the local advocacy service and put people in touch with that directly, basically by searching by postcode. It is hard for written communications to make it clear what the local advocacy service is because it is a different set-up, but when you come through on the telephone line, we can do that, and we do do that, so we would be referring people to advocacy where that would help.

Q479 Rosie Cooper: People will get a better answer if they phone you.

Dr Poulter: No, no. That is exactly the point I was making, wasn't it? You have vulnerable patient groups who may have to all intents and purposes what is, in the scheme of things, perhaps a less complicated complaint, but they may well be suited on the merits of the case because of their own circumstances to the requirement for having an advocate. That is why things need to be looked at on a case-by-case basis, but it is important that we have the PALS service that is responsive to individual needs, as well as to just referring the more complex cases where that is appropriate. That is, I think, a sensible approach to life.

Rosie Cooper: I really do surrender.

Q480 Chair: Certainly, Mr Webster from our earlier panel indicated that there was a capacity issue here. Is that something you recognise—that there is variation in capacity?

Dr Poulter: At a trust level, as trusts are realising, because of the increased powers that the CQC has, and the very diligent approach that Mike Richards is taking and the great strides he has taken in his role as chief inspector of hospitals, it is beginning to shine a spotlight, increasingly, on that unacceptable variability. I think that the focus the CQC has on listening to front-line professionals and their concerns about patient care as part of their inspection process, and also in looking at the complaints process, is something that will inevitably drive trusts to better resource the PALS process and their services. That will be a good thing.

Jane Cummings: When Mr Webster was talking earlier he was specifically referring to commissioning and commissioners, I think, and, yes, I think both Neil and I would agree that when we first came into being as NHS England we did struggle with capacity and our ability to deal appropriately with the people who were phoning in and raising concerns and complaints. So we have invested additional money; we have recruited additional staff; we are investing in a new management system to be able to track and look at concerns and complaints in a better way, and we have started to track very carefully what the people who contact our service actually think about the service. So we do ask on a regular basis, "Would you recommend this service? How happy were you with the service? Were you happy with the quality of the response, and so on, that you have had?"

We have started to do that on a regular basis and have seen some quite significant improvements. I think it was an issue of capacity. We have taken action and we are seeing the results. As Neil mentioned earlier, we will now review whether the systems we put in place are the best and whether we can improve that still further.

Q481 David Tredinnick: So far in this animated session we have heard absolutely nothing about Healthwatch, despite the fact that Healthwatch bills itself as the consumer champion. Minister, you smile at that, but how exactly does Healthwatch fit into the complaints scenario? What role do you, Minister, envisage for local Healthwatch organisations in complaints advocacy and complaints monitoring, please?

Dr Poulter: We all accept that there was considerable variability in Healthwatch's predecessor organisation, the LINks organisation, at a local level; I am talking about a local Healthwatch organisation tier at a local level. I think LINks organisations are incredibly variable in their reach, and I believe I am on record as saying that, as a doctor, I did not even know LINks organisations existed, which was not a good thing from a patient's point of view if medical professionals working on the ground did not understand what was available.

So the challenge was—and they have been in existence for a brief period of time—to make the successor patient voice organisation much more effective at being the patient's voice. How is that being done? First, we know that the Healthwatch organisations have an inherent link to local authorities now, and that gives them a much more systemic reach across the health and care system and they have a voice on health and wellbeing boards as well and reach into health and wellbeing boards to raise concerns. Also, I believe—I stand to be corrected—that there is a Healthwatch representative on the quality surveillance groups of commissioners at local level that NHS England had set up. Healthwatch are embedded in not just the health system but the health and care system through the link with local authorities, and their role of patient advocacy is much more embedded in the quality surveillance of the local NHS. I think they are in a much better place than LINks organisations to be effective in raising patient concerns.

Q482 David Tredinnick: Is there not a problem, in that at the moment local Healthwatch is involved in complaints advocacy only when commissioned to do so by local authorities? It is a reactive rather than a proactive organisation.

Dr Poulter: Local authorities, in terms of patient advocacy services, can commission their local Healthwatch organisations to do that, and that is something that clearly has a number of merits in helping to understand, in particular, how well the system is working in looking after more vulnerable patient groups, or how well the system is dealing with some of those more complex complaints that we discussed earlier. There is a lot of merit in that, and that is something I would certainly believe, as long as that is the best advocacy service available. There may be other providers of advocacy services which are more appropriate and better in that locality, and we have to be mindful of that, but there are a lot of advantages to Healthwatch being commissioned to provide those services.

Q483 David Tredinnick: Running on from that, you mentioned health and wellbeing boards, which are much more evident on the ground and have, I would suggest, been very effective in getting health and social care people involved if they are not directly commissioning services—at least people who are involved in local services and also local sports services at council level and things like that. Do you think there is a sufficient link between Healthwatch and health and wellbeing boards, which seem to have overlapping briefs?

Dr Poulter: If we want Healthwatch to be an organisation that is a genuine voice for some of the major issues that affect patients, there is clearly a role in how they feed into health and wellbeing boards. The health and wellbeing board is a focus for joined-up thinking and helping to deliver more integrated care, which is something I believe we are all signed up to, and that is more effective if there is a voice there articulating the patient's needs and concerns, and also it helps to bring a more co-ordinated approach to that patient voice across the whole system of healthcare, housing or the other priority areas that the health and wellbeing board is addressing.

Q484 David Tredinnick: Certainly, sitting on the Hinckley health and wellbeing board in West Leicestershire, I feel there is a strong case for Healthwatch making itself known and offering to attend, possibly, on occasions. I would like to suggest that to you.

Finally, local Healthwatch organisations currently do not have access to details of complaints data from providers and commissioners, which I would suggest to you hampers their monitoring role. Is this something you are prepared to review, please?

Dr Poulter: That is something that we are clearly looking at as part of the piece of work that the Department is co-ordinating on the complaints process: how we can collate complaints, can have greater transparency in future about the complaints process and potentially publish details—obviously protecting patient confidentiality—of how responsive they are, or how different providers compare with each other when it comes to complaints. That is part of our ongoing work, and something that could bring real benefits as part of our general drive for greater transparency in the system. Transparency about complaints is clearly an important issue and something that I am sure we would all want to see, as long as patient confidentiality is protected.

Q485 David Tredinnick: That is very helpful. I think, through you, Chair, Mr Churchill wants to come in.

Neil Churchill: To go back to the quality surveillance groups, Healthwatches are members of the quality surveillance groups, and the quality surveillance groups will see all of the anonymised data on quality. It is intended to be a single conversation looking at complaints, surveys, soft intelligence and clinical audit, and it is an opportunity, if there are concerns, to call risk summits and look particularly at organisations. Healthwatch is in a very good position to see all of that data, obviously on an anonymised basis. Those organisations, like Healthwatch in Merseyside, which also provide advocacy services, are taking their own portfolio of complaints management into those quality surveillance groups as one of the sources of intelligence that are used.

Q486 Grahame M. Morris: I think your officials might have been here, Minister, for the earlier panel, where one of the issues we talked about was when it was appropriate to complain or raise concerns through the commissioner rather than the provider, and I thought I would give an example. Yesterday, I was co-hosting a meeting in the Jubilee Room with Lawrence Dallaglio, the England rugby legend, where concerns were raised about the lack of access to advanced radiotherapy. There were 40 specialist oncologists and specialists in the

field there, and people who had lost loved ones for lack of access to this particular facility. It is an issue I have raised many times with the Minister. In these circumstances, there is no point complaining to the provider because it is you, NHS England, the commissioner, who is failing to provide the service. What redress do these people have in terms of raising this as an issue? Do they use the NHS Constitution, or do they complain to you, or do they complain to the Minister—to Dr Poulter?

Neil Churchill: The starting point would often be clinical standards, which would set out what the expectations are that patients are to have access to, and commissioners have a responsibility to commission care which meets those clinical standards. The expectation would be that, if a commissioner is not doing that, then somebody could complain that that was not the case and there would need to be an explanation provided.

Q487 Grahame M. Morris: But, Mr Churchill, in this particular case you have reneged on a promise, or your organisation has. The Prime Minister gave an assurance that access to advanced radiotherapy would be rolled out across the country. There were a series of meetings at which NHS England were involved and other stakeholders, providers, specialists and so on, and the latest information is that that is not going to happen. What recourse do they have? It is just lack of access.

Neil Churchill: I am not familiar with that particular example, so I would be very happy to take that away and look at it and come back on it.

Q488 Grahame M. Morris: I would be grateful if you would. Will you write to the Committee?

Neil Churchill: Yes.

Q489 Grahame M. Morris: I am grateful. Minister, do you have any responsibility in this regard, when both the provider and the commissioner failed? What is your role in the structure?

Dr Poulter: You are talking, I think, about an access to services issue, and there has been, historically, a lack of access to the services that you are describing. The Prime Minister made it a priority to put the funding and attention into that. I believe that is very clearly outlined in the mandate to NHS England, and the Secretary of State holds NHS England accountable at accountability meetings for key priorities, both inside the mandate and other things that are not key priorities for the NHS. That is something that happens, certainly at the very least, on a quarterly basis on large issues of concern.

Q490 Grahame M. Morris: This is new territory to me and it may well be to you because the mandate is relatively new. If there is a breach of the mandate by the commissioner or the provider, what recourse does the service user have? Do they have a right under the NHS Constitution? What alternatives are open to them?

Dr Poulter: In terms of the services, there is a priority for NHS England to deliver these services. There is money given to NHS England to do that, because we want to be leading

the way and making sure we have the highest possible quality of patient services available for patients. I am not sure this is quite the news to you that you are outlining. I think we were both on the Bill Committee when all these frameworks were discussed about the accountability framing. You will probably remember as well as I do that it was the longest-standing parliamentary committee, I believe, certainly this century, in terms of being reconvened, and there were in-depth details about how many of the systems of NHS England work. But this is not an issue.

The reason it has become such a priority is because we want to be leading the way in delivering these services and there is a clear priority in place to deliver that. It is through those accountability meetings that the Secretary of State holds NHS England responsible for making sure the operational delivery of this is delivered. That is something that I will take away from here as a concern that you have raised and one that we will, I am sure, be very happy to write to you about in further detail to give you some reassurance.

Q491 Grahame M. Morris: Minister, it would be really helpful if you would look into it, because it is a matter of some concern. We are looking at the whole issue of raising concerns and complaints, and whether it should be the provider or the commissioner, but here there is a failure on both counts. There is a political commitment, and a relatively small allocation of capital, either by the NHS capital allocation or through charitable foundations, would buy this kit. For want of a relatively small sum of money to pay for the trials and their support, this could be taken forward and that pledge could be honoured.

Dr Poulter: Absolutely, and I take on board your support.

Grahame M. Morris: I would be grateful if you would come back to the Committee on that.

Chair: Andrew wants to come in next, and then Robert.

Q492 Andrew George: A theme that has been pursued both in our inquiry and in your answers so far is the grouping of complaints and concerns. Is it possible to disaggregate complaints from concerns, in your perspective, just for a moment? Given that NHS England is no doubt undertaking and keeping a monitoring weather eye on what is happening on the ground, to what extent are you able to disaggregate between complaints where patients or their families are seeking redress or compensation, and concerns and feedback for which issues are raised, hoping that that will result in similar circumstances never happening again, or that the standards are driven up as a result of it? A third category is those circumstances where the patients raise concerns but, as a result of the frustration of not having those concerns addressed, end up in a more combative complaints system which could have been avoided. From your perspective, are you seeing patterns there, and can you disaggregate between them and see either that the majority are genuine complaints seeking redress or are concerns?

Dr Poulter: There are a number of issues there, Andrew. The first issue is slightly linked to the previous question on access to services. While I thank, and I am sure that the Prime Minister will thank, Mr Morris for supporting his ambition to deliver world-class radiotherapy services—

Grahame M. Morris: You haven't done it; that is the problem.

Dr Poulter —that is something that NHS England will look into, and I will make sure that I am the Minister who writes back.

Q493 Andrew George: I am sorry, but could you speak up a bit?
Dr Poulter: I am doing my best to speak directly into the microphone. I am sorry; I am being medically soft-spoken this afternoon. The very real concern has been—I think much more in the past—how in those hospitals that do not deal with complaints effectively there is a push towards litigation. I think that may have been your last question.

Andrew George: That is right, yes.

Dr Poulter: That is, I think, a very real issue and one that can only be dealt with effectively by changing the culture and the approach in the hospital to how they deal with bad things happening to patients. It is not about closing ranks, but about saying that a bad thing has happened, acknowledging and accepting that a bad thing has happened, and making a frank apology. An apology is not an admission of liability in a legal sense; it is just doing the right thing, acknowledging that something has happened. It is about how we foster that culture.

In the Care Bill that has just gone through, essentially, a duty of candour has been introduced, and I believe the regulations have just been laid in respect of that as well. That is about prima facie saying that all hospitals have a duty to be open and honest with patients when bad things have happened to them. That is a proactive duty, and the CQC can have a role of enforcing that. It is a proactive duty on all providers of care now to be open and honest when something has gone wrong. That is a big step forward in making sure it is a proactive process, rather than a reactive process in the past. That will be very helpful in setting the right tone.

The other issue is that there is also an approach that needs to be taken here—and there is a role that I think is increasingly coming in through the training of the next generation of healthcare professionals—about how we encourage and support our work force to be much more open in their approach, and the softer skills involved, when things have gone wrong. Perhaps the generation of doctors that I represent have picked up some of those skills, and there is sometimes work to be done with some older professionals who have been working for a number of years. Many do it very well, but there are some who perhaps need additional support and training in that, and that is something that is available and can be supported. If we get to the point of litigation—and people may always want to go down that route as a matter of choice—sometimes it is because the complaints system has failed. A more open culture, a duty of candour, having staff with the right training and support to engage in the right way when things have gone wrong and recognising the importance of saying sorry will put us in a better place going forward. I hope that has answered your questions.

Q494 Andrew George: I do not know whether Mr Churchill wants to come in as well, but I wonder whether the distinction between the two—concerns and complaints, with

redress and feedback driving up standards—is properly understood and, if you like, mapped, and whether you can see the relationship between the two and disaggregate them as well. I think they are sort of bundled together, and possibly you end up with concerns becoming complaints because they are not well handled at the first stage. Is that something you have seen?

Neil Churchill: We try to work on the basis of how the complainant or the patient wants to proceed and what they want out of the engagement. We work with the Patients Association definitions, which point out that any concern or complaint should be treated seriously in a similar way, and that someone who is pursuing a complaint might want the service to improve rather than any particular redress.

The thing that has really made a difference in the past year has been the friends and family test, and the Minister mentioned that earlier. We have now had over 3 million pieces of feedback from the friends and family test. The vast majority of those are positive, but a significant minority are about areas where we need to improve. The significance is that clinical teams are looking at that feedback on a weekly basis, looking at where the service needs to improve and then making improvements in real time. We are creating a sense in which patients feel that, if the bins are keeping them awake at night, they can actually say that while they are on the ward. It will be registered, and, as quite a lot of trusts have done, they have put in soft-closing bins which make it easier to get a good night's sleep. If we do that more consistently, we should reduce the need for people to go down a formal route of raising a complaint.

Q495 Robert Jenrick: I want to ask a quick question which builds on the last two questions about the distinction between formal complaints and comments and feedback. Of course, not every comment or complaint is about patient standards or service. They can be about the services that are being provided or the configuration of services within a particular area, which, of course, is pertinent to the area I represent, which is going through a quite significant reconfiguration of services. How well do you think the public understand how they would go about making comments of that nature, which are not formal complaints but are really about the placing of hospitals and the nature of the services provided in an area and the commissioners? Is it widely understood by the public that that may be a route they want to go down, and how well are the commissioners placed in practice to respond in a meaningful way to people's concerns?

Dr Poulter: There are two very important issues there. First, there is the point about whether people even understand, in some cases, that they can complain to commissioners about the services they receive. The immediate thought is, "I have to go to the person who provides the service," or, "I raise a concern that that service is not provided in the place or the way I would like it to be provided." There is a role in that for helping to flag up through the bedside guide, as I put it—the patient guide to making it clearer—how and who you can complain to; there is a role for that guide. There is also a role for Healthwatch organisations in collecting intelligence from the local population and in their other roles to raise this, particularly through the health and wellbeing board, as a fulcrum for delivering integrated, joined-up care across the health area.

There is also the other issue, which I do not think we have talked about today but I am happy to elaborate on, which I know you all know about: the duty to engage and fully

consult with the public if there is a substantial service reconfiguration. That is part of the reconfiguration process in itself. There are two issues in that. One is: where there are not perhaps services being delivered in the right way or place, how can Healthwatch engage in that or how can people know they can raise issues and concerns directly with commissioners? The other issue is that, where there is a service reconfiguration, there is a need inherently to consult and make sure that people do not feel "done to" but are part of the process and can help to design their services. That is something, as a Government, on which we have tried to get into a better place compared with where things were maybe a number of years ago.

Q496 Robert Jenrick: If people felt the consultations or listening exercises, or whatever may have happened in a community, were insufficient or inappropriate, do you feel that there is a sufficient awareness among people about how they might comment or make a complaint about those?

Dr Poulter: Certainly, when it comes to complaining and understanding how to raise concerns about how services are commissioned, you are right that there has been a lack of clarity, and that people perhaps are even unaware that there is a route or somebody to talk to about that. That is something for which I hope this bedside guide will be helpful. It will also be helpful in flagging things up, in people better engaging perhaps with local Healthwatch organisations and supporting the work that they do as advocates for the needs of local patients. Of course, if on the other issue of service reconfiguration people feel aggrieved by the process, there is the power for referral in at a local authority level to the Secretary of State in some of those decisions.

Chair: I am going to come next to Charlotte on Francis.

Q497 Charlotte Leslie: I have a very quick question. The Government have commissioned Robert Francis to lead a review of whistleblower protection, and on how we can support back into employment people who have blown the whistle and have vindicated concerns. Will such a review be retrospective? Will it look at historical cases and at delivering some justice for those who have historically blown the whistle? I am thinking particularly of someone like Sharmila Chowdhury, who has suffered a lot. Will it be historical?

Dr Poulter: My understanding, as you will be aware, is that the Secretary of State has had meetings with a number of whistleblowers and had some personal discussions to help him form the process of getting to the point of launching Robert Francis' work. My view, when there is a piece of work going on like this, is that given that Robert Francis has done a very good piece of work in his inquiry following up on Mid Staffs, and on the terrible events that took place at Mid Staffordshire hospital, I would not wish to bind his hands by being prescriptive about what he may or may not be doing. I would think it inconceivable that in such a piece of work he would not be talking to people who have been whistleblowers in the past.

Q498 Charlotte Leslie: So you cannot say yet.

Dr Poulter: I think it would be inconceivable, if you are doing a piece of work, that you would not talk to people who are whistleblowers.

Q499 Charlotte Leslie: My specific question—I think your answer is "I can't say yet"—is: will the measures taken be retrospective? Will they deal with retrospective historical cases in terms of providing support and justice? I think the answer you have given is, "It is under discussion," and you cannot say yet. Am I right?

Dr Poulter: You have to be careful, as we all know in the law. You cannot make retrospective decisions that will be to people's disadvantage. You can't create a new set of parameters and then judge things by a new set of rules.

Q500 Charlotte Leslie: But in terms of whistleblowers who have been vindicated in blowing the whistle and supporting them back into employment, I would not see that as a disadvantage to anyone. In fact, I would see that as an advantage to the entire system.

Dr Poulter: We have to see what Robert Francis comes forward with in his proposals.

Q501 Charlotte Leslie: So it is under discussion, and "Not yet."

Dr Poulter: Robert Francis is going to take a view about what to do his work about, and he will make recommendations based on that work. There is not much more that I can say about that at the moment.

Charlotte Leslie: So it is under discussion, and "Not yet." Thank you, Minister.

Q502 Grahame M. Morris: I hope I am not going back, but just to cover a bit of ground in a little more detail, we know that the Department has indicated that it expects trusts to have procedures in place to encourage and support staff to raise legitimate concerns. Both the Department and NHS England expect providers to give staff that support, or are expected to give support to staff who feel they cannot use those procedures. I want to give you two examples and I would like your comments on them. The theory sounds great, and we would all agree with that, but for example in west Yorkshire, where ambulance staff raised concerns about patient safety because of the staffing ratios and mix, the response from the provider—from the employer—was to de-recognise the trade union. In Northampton general hospital, staff have been effectively locked out of the pathology department for raising concerns about patient safety because of the temporary untrained staff who have been brought in to do various analytical tests. What are you doing, Mr Churchill, and you, Minister, to support the legitimate concerns that those staff groups are raising?

Dr Poulter: I note your Unite badge and your affiliation to that union.

Q503 Grahame M. Morris: They are my trade union, yes, and they have a right to be heard and to raise legitimate concerns.

Dr Poulter: Absolutely, and we have a very good relationship. Before I came to this meeting today, I was chairing the Social Partnership Forum, which involves NHS Employers and trade unions, and out of discussions from that group there was guidance produced about facilitating and supporting staff, be it managers or front-line staff, to raise concerns. That is something that has been disseminated, supported and gone through to help all members of staff in the NHS understand that it is something that should be routinely part of their job which they should be able to do free of fear. That is something on which employers and trade unions have been working on together collaboratively, on a number of issues, and something that is beginning to permeate through the system. We cannot underestimate the impact that the Mid Staffordshire scandal and the Francis inquiry had on health and care providers. The reaction to that has been very positive in terms of recognising the importance of listening to and properly engaging with staff. The steps that have been taken on the friends and family test and about having a duty of candour, which is going to be introduced through the Care Bill and the regulations, will help to foster a much more open culture and support, just routinely, it being the case that staff should be listened to when they have legitimate concerns about patient care.

Jane Cummings: I will pick up the issue from NHS England's point of view. There are a variety of things that we are doing and, as the Minister just referred to, from April we started the staff friends and family test. That does give some very specific feedback on a much more regular basis than the annual staff survey. As well as that, we have a very strong programme of work, which, although it has been based around the nursing agenda, is relevant to all staff, around staff experience. We know from the research of Professor Michael West at Lancaster university that staff who feel well engaged, well supported and empowered to speak out and have clear aims and objectives, who feel that they are working in good teams, have a very positive impact on patient experience and patient outcome.

The other piece of work that we have just kicked off is that we have started to publish on a patient safety website. We have only done it once, but as part of that safety website there is a section called "Open and honest reporting" where organisations—not yet ambulance trusts, but they will be—will be RAG-rated. One of the things that we measure is the staff view and how well they are able to speak out. If you take some of those very specific actions that we are doing and you link that through to areas such as the quality surveillance groups that we have talked about already, there is an opportunity to learn from that how staff feel about their ability to speak out and raise concerns, and what the impact is in terms of quality locally.

Q504 Grahame M. Morris: The Minister wants to reply, but can I just ask this? In the circumstances you mentioned about the ambulance trusts, what is your view of an employer or a provider taking punitive collective action like de-recognition, or, in the case of the pathology department in Northampton general hospital, locking out the staff without pay? Is that a reasonable response?

Jane Cummings: It is very difficult to comment on individual cases. I am not aware of the details of either of those, but the principle—and it is a principle that I feel very strongly about—is that we have to look after our staff, we have to respect our staff's views and we have to encourage and empower our staff to speak out. We know that not only does that

mean they are able to do their jobs to the very best of their ability, but it also has a very positive impact on patient care, patient experience and patient outcome. That is why we are in these jobs.

Q505 Grahame M. Morris: I agree with that, but forgive me, Minister, I want to pursue this and then I am done. On that basis, can we conclude, if an employee or a group of employees acting collectively in a trade union, for example, have to rely on the protection of the Public Interest Disclosure Act to raise a concern, that the provider's procedures have failed, and would you, as NHS England, take some action there?

Dr Poulter: I think you are conflating two things here. First of all, the Public Interest Disclosure Act is something that would apply to, if you like, a confidentiality clause as part of probably a dismissal settlement, and that is not the scenario that you have just raised. I do not see quite how that would come into play on any of those scenarios. I think you are conflating two things, and I am sure that was just a misunderstanding.

The important point on staff—and it is important to read it out—was made by Mike Richards when he gave evidence to you earlier on this. When the then Chair mentioned the engagement with staff, Mike Richards made this point on CQC inspections, which I think is important, about empowering staff to speak out: "We always hold focus groups for junior doctors, senior doctors, junior nurses and senior nurses, admin staff and allied health professionals so that they can come in their professional groups. I often go to the junior doctor focus groups if I am on an inspection, and they are very revealing. They tell it as it is, in my view. They are sometimes extremely good and positive about a trust, but sometimes less so; you can get down to the level of the individual department and we also have information from the GMC training survey, and the two do very often match."

That, if you like, is the crux of this matter. The CQC, as the safeguard, champion and protector of the patient, are very much putting listening to staff feedback at the core of everything they do.

Jane Cummings: Absolutely.

Dr Poulter: That means that the staff voice, when staff concerns are raised, should always be heard. That is a big step forward from where we were a few years ago.

Q506 Rosie Cooper: The Department states in its memorandum that it does not have legal powers to investigate concerns. Why not?

Dr Poulter: A memorandum on what?

Q507 Rosie Cooper: From the Department: "Although the Department does not have legal powers to investigate concerns, to ensure that any whistleblowing correspondence we receive is handled appropriately"—

Dr Poulter: I am sorry, but I am still stuck.

Andrew George: It is a memorandum to us.

Dr Poulter: Indeed, but what particular, if you can—

Q508 Rosie Cooper: I will read out the bit: "The Department has set out its own policy on dealing with issues which are raised directly with the Department or Ministers. Although the Department does not have legal powers to investigate concerns, to ensure that any whistleblowing correspondence we receive is handled appropriately, a dedicated team" looks at it. So you do not have legal powers to investigate.

Dr Poulter: That is because those powers are vested in common law, potentially through tribunals. There are powers vested also in statutory bodies like the CQC, as protectors. It would be quite extraordinary, if we are worrying about cover-ups, if the Department of Health was in a position where it was primarily responsible for investigating complaints in the health system; that could be accused of being political interference and there could be other problems. One of the things the Secretary of State has been very clear about is the independence of the complaints process in the CQC, and there is also a common law remedy for others as well.

Q509 Rosie Cooper: As the accountable person for the NHS—I was going to ask, "what action is available to you?" but I will re-phrase it—what actions are available to the Secretary of State when a serious concern about a provider comes to his attention?

Dr Poulter: We won't rehearse the political arguments here, because I do not think it would be constructive in a Select Committee, but there were a number of issues that were raised towards the dying days of the previous Government about the direct involvement of, potentially, Ministers in not facing up to failures in quality of care—

Rosie Cooper: So the answer is none.

Dr Poulter—and potentially being involved in turning a blind eye to serious concerns in the system. This Secretary of State has taken a view that it is important that the complaints system and patient protection is independent of the political process. That is the reason why we now have a chief inspector of hospitals, an enhanced role for the CQC, and the patient protection function is now an independent function. That is something I think we should be proud of and not deriding.

Q510 Rosie Cooper: I will ask you again: what actions are available to you, as a Minister, or to the Secretary of State as the accountable person, when a serious concern is brought to your attention? What do you do?

Dr Poulter: Routinely, if I am alerted to the concern—as you will be aware from letters I may have written to you or other Members of Parliament—if the concern is serious enough, we will pass on those concerns to the Care Quality Commission or other organisations so that the Care Quality Commission can be informed of the correspondence that has been raised with us.

Q511 Rosie Cooper: So you have no power at all. The Prime Minister, in answer to my parliamentary question, was very clear with regard to HR. I mentioned it before. I asked for a forensic investigation into HR practice at Liverpool Community Health Trust. His answer was yes, but he sort of inferred that the CQC would do it, so there is confusion here. I have also spoken to Simon Stevens. There is nobody responsible to investigate that, so if I bring you real, serious complaints of a trust bullying its staff and using HR mechanisms to control its staff, who is responsible? Tell me who investigates.

Dr Poulter: It would then be for me to make sure, looking at your concerns, that that was passed on to the relevant body to investigate.

Q512 Rosie Cooper: Which relevant body?

Dr Poulter: It would depend what your concerns are.

Q513 Rosie Cooper: Right. We are very clear.

Dr Poulter: But we are not very clear.

Q514 Rosie Cooper: Well, we can stay here all night and I can go through every one them.

Dr Poulter: Then perhaps it would be appropriate to do it at another time.

Q515 Rosie Cooper: Absolutely, but let me be very clear that Liverpool Community Health Trust used HR policies, HR practices and threats to report people to the NMC—things like that—to ensure the compliance of their employees, because if they did not comply they would eventually be dismissed. I have had many a report which says, "You see people one day and they have gone the next." I put it very clearly to the Prime Minister. He thinks the CQC can do it. The CQC have very clearly told me they cannot. I have spoken to NHS England's chief executive. Who does do it? Does anybody know?

Dr Poulter: My understanding is that Ian Carruthers is doing a review of governance at the Liverpool Community Health Trust, and I would have to write to you with greater detail, with greater specifics, but as you know, there is a responsibility between the CQC and either Monitor or the TDA, depending on the trust; in this case it is the TDA that will oversee that process.

Q516 Rosie Cooper: The TDA have asked Sir Ian Carruthers to go and look at governance and the kind of things that the TDA look at—culture and all of that—and I am sure that will all sort itself out eventually. My question is, in terms of bullying and looking at retrospective HR practice where an organisation has been frozen, people have lost their jobs, careers have been ruined and people's health has been ruined, who is responsible for looking at it? The Prime Minister thinks it is the CQC, and I accept that we do not have an answer, so perhaps, if you would not mind, you could look at this after the meeting and tell me who does actually look at this. Who actually deals with it? Would that be possible?

Dr Poulter: Absolutely, and I think clearly it is, in general terms, the CQC and the relevant regulator, TDA or Monitor.

Q517 Rosie Cooper: They don't have those powers. They are very clear. I have spoken to David Behan. Perhaps you need to go and look at it because what you are saying is not accurate.

Dr Poulter: I have explained to you already that there is a review taking place and the way that review is going. I am very happy to write and explain to you the details of that review because I do not have those immediately to hand—

Q518 Rosie Cooper: Please do, thank you.

Dr Poulter: It is quite a specific case that you have raised.

Q519 Rosie Cooper: But it is symptomatic, because if you cannot find it there and we do not know who is responsible there, we do not know who is responsible anywhere. This could be going on under the radar anywhere. Not even the unions managed to see it. They are all standing back, horrified: "Could this have really happened on our watch?" The ACAS report says, "Yes, it did." Who is responsible? I would be grateful if you could come back on that, as probably that is the easiest way of dealing with that one.

May I just ask you, Minister, if you would encourage someone who has serious information to offer it up to the system, to the health service, to a provider, despite them having signed a compromise agreement when they left the trust as a result of their raising concerns? Would you still encourage them to speak out?

Dr Poulter: Under the Public Interest Disclosure Act—PIDA —you cannot have a gagging clause as part of any agreement when someone leaves a trust. That is clearly not legal. So they should be free to speak out about patient safety concerns.

Q520 Rosie Cooper: In reality, people are very nervous, Minister, and I am asking to get it on the record simply because there are people whose families are saying, "No, no, no, please don't do it. We can't afford the loss of that money, where you can't get a job and we are in limbo. Please don't speak. Stay silent because we can't risk it."

Dr Poulter: Clearly, it is illegal to gag someone if they have concerns about patient safety in that way under that Act. Therefore, of course, people should feel able to speak out. Obviously, as distinct from an administrator—unless of course they are paid up to a regulatory body—often a front-line professional, a doctor, nurse or another allied health professional has an inherent professional responsibility, as part of their registration and part of being a good doctor, nurse or midwife, to speak out. Of course you would expect a front-line professional to do that anyway, and they should never be gagged from doing so.

Q521 Rosie Cooper: Thank you for that, Minister. Does that include just patient safety? For example, if a senior employee knows that a trust is perhaps selling cancer tissue samples to pharmaceutical companies without the patients' knowledge, should they still be free to speak?

Dr Poulter: I am sure if they had concerns about any activity that was an issue for the Human Tissue Authority, or someone else, they should raise that concern with them.

Q522 Rosie Cooper: But should they still be free to speak under your patient safety?

Dr Poulter: If they feel there is something happening that is illegal, of course they cannot be gagged from speaking out against something that is illegal.

Q523 Rosie Cooper: What I am really trying to get at is that the Public Interest Disclosure Act does not just relate to patient safety.

Dr Poulter: The Public Interest Disclosure Act is about gagging clauses and is fundamentally focused primarily on patient safety, but of course you cannot stop someone from speaking out if there is an illegal activity going on, because your employment contract, and the circumstances of your departure and your clause on departure, is related to that. If there is something illegal going on, of course it is important to notify the appropriate authorities about that.

Rosie Cooper: Thank you.

Q524 Chair: Can I raise another issue, about another pathway for the complaints processes—where people make a complaint, for example, to the GMC? You will know, Minister, that there was a draft Bill from the Law Commission, which was not in the Queen's Speech, about the regulation of health and care professionals. One of the effects of that has been that the GMC, who would like to be able to challenge decisions where they have been thrown out by a panel, would like to be able to appeal panel decisions and now are not able to do that. Also, as you will be very familiar, there is the issue about the separation of regulation and supervision of midwives. Are you able to set out which aspects of that draft Bill are going to be taken forward in secondary legislation? It is something that I asked in the Queen's Speech debate but I have not had a response, and I think there are very many organisations that are keen to hear which aspects of that secondary legislation are going to be taken forward and what the timetable for that will be. Would you be able to write formally to this Committee to set out what aspects are being taken forward, but also perhaps which aspects are not being taken forward, so that they can be examined?

Dr Poulter: I am very happy to do that. This is a clear priority. There are some issues that we can take through section 60 orders, and we will do so in conversations with the regulators. There are some section 60 orders which we will be going out to consult on with the GMC very soon, and there are others with the GDC and other regulators that we are looking at taking forward. The timetable for taking through a section 60 order, with the consultation process, can be a few months. I am very happy to write to the Committee with the list of section 60 orders which we think are likely to be able to be delivered in the lifetime of this Parliament, which I think would be helpful.

Q525 Chair: That would be very helpful, particularly in the context of an inquiry about complaints and concerns. There are very many of these that are directly relevant to complaints and concerns, so it would be nice to know not only the ones that you are going to include but the ones that you have decided you are not going to have time to progress in this Parliament, and what measures you are going to take to address the concerns that were raised in the Law Commission draft Bill.

Dr Poulter: Absolutely. If I can be reassuring, I had a number of conversations with the regulators last year about what, for them, were key priorities to take forward to section 60 orders, and that we would be very keen to support them in progressing on the back of a number of the recommendations to this Committee and things that regulators have recognised as priority areas. The work has been going on into those, and I believe, off the top of my head, there are about five or six section 60 orders that we are looking to deliver in the lifetime of this Parliament. One or two of those are at quite an advanced stage, and we will be going out to consultation on them quite soon. Others will need a bit more work-up, but I am hopeful that I will be able to reassure the Committee that there is considerable progress on a number of these areas.

Q526 Chair: Thank you. You will be writing to me formally on that issue.

Dr Poulter: I will be writing to you and I can do that, I am sure, before the recess.

Q527 David Tredinnick: On that, you have no doubt seen our report on the Health and Care Professions Council. The scope of that organisation is clearly very important when it comes to regulating a number of bodies. At this stage do you have any comment on what we have said in this report, or is that premature and you would rather wait until you publish a response, which would be perfectly reasonable?

Dr Poulter: You will forgive me, but I will wait until we publish a formal response.

David Tredinnick: Fair enough.

Q528 Chair: If you could write to us to let us know when that response will be forthcoming, it would be very helpful.

Dr Poulter: In the letter I write about the question of regulators, I will put in an additional note to give an indication of what we think the timetable will be on that.

Chair: Are there any other points that the panel feel they would like to comment on that you have not been asked about? No. Thank you very much for your time, and apologies again for keeping you waiting. Thank you.